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children

A PROFESSIONAL JOURNAL ON SERVICES FOR CHILDREN AND ON CHILD LIFE

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(*formerly* THE CHILD)

Back of Dr. Nicholson Eastman's thinking about the problems of maternity care are three decades of professional work in obstetrics, both as teacher and practitioner. He served as associate and professor in obstetrics and gynecology in Peiping Union Medical College, China, in the 20's and 30's. Since becoming obstetrician-in-chief at Johns Hopkins Hospital in 1935, he has authored a book, Expectant Motherhood, in 1940, and coauthored (with L. Zabriskie) Nurses Handbook of Obstetrics, in 1943.

Child Study Association of America, which Dr. Gunnar Dybwad has directed since 1952, has been outstandingly successful in disseminating information on child development and in raising the professional level of parent group education. Dr. Dybwad served from 1942 to 1951 as State Child Welfare Director in Michigan. Currently he is chairman of the Committee on Child Welfare of the National Council of Churches of Christ, and of the Parent Education Section of the National Council on Family Relations.

Dr. Fritz Redl, one of this country's foremost authorities on child group psychology, left his professorship in social work at Wayne University, Detroit, Mich., to undertake his present study. Austrian-born, Dr. Redl received his doctor of philosophy degree from the University of Vienna and his training in child analysis from the Vienna Psychoanalytic Institute. His books, Children Who Hate and Controls from Within, have received wide acclaim.

Harriett Bartlett's interest in defining the function of professional social work has been ably demonstrated in her continuing participation in study projects of the American Association of Medical Social Workers and the Council on Social Work Education. Before taking her present post as professor and director at Simmons College, Boston, she was associated for 20 years with the Massachusetts General Hospital.

The Pennsylvania Citizens Association, through its alert magazine CURRENTS, led us to the story, felicitously told by Helen C. Hubbell, of how child welfare services came to Sullivan County, Pa. Miss Hubbell's 30 years in child welfare have included experience in voluntary and private agencies in New York, Massachusetts, and Pennsylvania.

When Betty Hutchinson went to Panama as a technical consultant, she could walk right into her job with no language difficulties because her first 13 years of life, spent in South America, had given her an excellent knowledge of Spanish. Her professional career includes 3 years as a hospital social worker, under the Red Cross, in India, Korea, and the Philippines.

frontispiece

"From looking in their faces comes again pride in being human, and a sense of infinite possibility in mankind."

Ernestine Evans, Author.

These Detroit, Mich., school children were photographed by Ralph Showalter for the United Automobile Workers–CIO.

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CHILDREN'S BUREAU

Martha M. Eliot, M. D., *Chief*

TO OUR READERS

THIS NEW PROFESSIONAL JOURNAL on services for children and on child life arrives in time to herald the 42d birthday of the Children's Bureau which occurs on April 9, 1954. A publication of the Bureau, but not its captive, CHILDREN will, nevertheless, reflect the Bureau's objectives.

Throughout its history, one objective has towered above all others, and this one, we frankly admit from the beginning, will color and shape the contents of CHILDREN: the objective of providing ***a basis for action in behalf of children.***

• • •

Two women and two committees of the Congress can take credit for launching the Children's Bureau in this direction more than four decades ago.

The two women were Lillian Wald, founder of the Henry Street Settlement, in lower New York City, and Florence Kelley of the National Consumers' League. Their story deserves to be told again.

On a day in 1906, while they were having their morning coffee at the Settlement, two letters came in the mail. "Why is it," one of these letters asked, "so many children die like flies in the summer time? Is there something I can do to help matters?" The other letter was from a mother whose husband had died. She was troubled because, now that she had to go out to work to support her children, she would have to put them in an institution.

"There must be thousands of mothers all over the United States in just the same situation," observed Miss Wald. "I wish there were some agency that would tell us what could be done about these problems."

Miss Wald and Mrs. Kelley turned to the morning newspaper. The Secretary of Agriculture, the paper reported, was going South that day to find out how much damage the boll weevil was doing to crops.

That gave Miss Wald an idea.

"If the Government can have a department to take such an interest in what is happening to the Nation's cotton crop, why can't it have a bureau to look after the Nation's crop of children?" she asked.

Miss Wald passed the idea to a friend who wired it to President Theodore Roosevelt. "Bully!" the President wired back, "Come down and talk to me about it."

Six years later the idea had matured into the law creating a Children's Bureau and charging it to investigate and report "upon all matters pertaining to the welfare of children and child life among all classes of our people."

That this investigating and reporting were to be for a purpose was made amply clear by the two Committees of the Congress which recommended the creation of the Bureau.

Information is needed, said these Committees "to enable them (the States) ***to deal*** more intelligently and more systematically and uniformly with . . . the betterment of the conditions of children," and "in order that they (the various charitable and humane organizations interested in the welfare of children) ***may do their work*** more wisely and effectively."

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These directives clearly marked a difference between the Children's Bureau and such research agencies of Government as the Bureau of the Census, for example. The latter has always been and still is a fact-gathering organization; it carries no responsibility for the application of the facts which it gathers and reports. The Children's Bureau, on the other hand, was charged with contributing to the "betterment of the condition of children," according to the Senate Committee, and its investigations and reporting were to that end. Since fact finding was to lead to action, it was not enough that the Bureau find out merely ***what*** was happening to children. It must study, too, ***why*** it was happening, and ***how*** "abuses" could be "checked." The history of the Bureau's investigations and reports is alive with the ***what,*** the ***why,*** and the ***how.***

With a stream of facts flowing out to citizens on how good jobs are being done, and how they might be done, it was a logical next step for citizens, eager for action, to look to the Bureau for help in doing good jobs.

Responding to this demand, from its earliest days and throughout its life, the Bureau has, with the help of outstanding authorities, developed standards of good care in many fields.

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But knowing what is good to be done is not always enough. There must be the wherewithal, as well as the know-how, to bring good practices to life.

So the third logical next step was taken by the Congress when it made the Children's Bureau responsible for administering various laws to help States financially in improving the conditions of children.

The first of these laws was passed in 1921 when the Congress authorized $1,200,000 to be given each year to the States to help them improve their health services for infants and for mothers during childbearing. The Children's Bureau was made administrator of these history-making grants-in-aid.

The Federal Maternity and Infancy Act had a relatively short life. It expired in 1929, but it laid the ground for title V of the Social Security Act, passed in 1935 and in operation continuously since, authorizing funds to be given annually to the States to extend and improve health and welfare services for children.

To assemble facts needed to keep the country informed about matters adversely affecting the well-being of children; to determine what kinds of

health and welfare measures and methods are most effective in aiding children and their parents; to work with citizens and agencies in improving the conditions of childhood; and to administer the financial aid that the Federal Government gives to States for this purpose: these, then, are the interlocking, intermeshing purposes of the Children's Bureau. It is good practice for financial aid to be based on knowledge of the facts and standards of service. Knowledge of the facts and good standards that fail of application are sterile.

Enormous changes have taken place during the Bureau's 42 years in the character of children's problems on which action is needed. The tally of achievements is too long to list here. They are accomplishments of the Nation in which this Bureau has played a part, but only a part.

• • •

Alfred Lord Tennyson once said:

Yet all experience is an arch where-thro'
Gleams that untravell'd world whose margin fades
For ever and for ever when I move.

The margins of the untraveled world of the good life for all children seem not to shrink, as progress is made in defeating one enemy of childhood after another, but to grow with discovery and experience. A purpose of CHILDREN will be to bring those margins nearer by reducing, if it can, the time lag between discovery and application.

A chief method of science, Harry A. Overstreet observes in his book, The Mature Mind, has been that of ***dividing to conquer.*** "By this method," he writes, science "has put at our disposal a well-nigh incredible body of facts regarding everything from the behavior of the atom to the behavior of the human mind confronted by a problem."

This proliferation of approaches both to problems and to solutions shows up dramatically in the history of child care. One development of greatest significance in the first half of this century has been the growth of specialization in professional services for children. No State or local health department offered in 1912 the range of services that the average one today provides. Child welfare divisions in State departments of welfare were nonexistent.

"Now, apparently," Professor Overstreet predicts, "science is ready for a new method: that of ***uniting to conquer.*** What has been divided and subdivided for purposes of research is now being reassembled for purposes of interpretation and of application to human affairs."

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In keeping with this new method, CHILDREN will address itself "across the board" to all professions concerned with the well-being of children. It will direct itself to practitioners, executives in programs, teachers in professions, and research workers, whatever their specialty in child care is. By intentionally favoring material of interest or concern to more than one profession, CHILDREN hopes not merely to add to interprofessional understanding and teamwork but also to multiply the effectiveness with which each profession deals with its own problems.

CHILDREN will offer its readers a balanced fare of technical articles on health, welfare, and child development. It will relate what needs doing, and why; who's doing what, and how. It will include data, discussion, and debate, on the physical, social, emotional, and cultural aspects of child growth and development; on standards of child care and professional training; on developments in professional techniques, personnel, and in programs serving children and their parents.

CHILDREN is designed to be neither house-organ nor oracle of the Children's Bureau. It will be a medium of exchange of ideas between and among professional people. As a journal of exchange, principal contributors to CHILDREN will be persons outside the Children's Bureau. CHILDREN will welcome, particularly, contributions from persons of professional competence who can give another side of, or a new slant on, a subject which it has already presented.

While the contents of CHILDREN will, of course, be in harmony with administrative policies of the Department of Health, Education, and Welfare, the point of view of no article by an author not in the Children's Bureau is necessarily that of the Children's Bureau. There will be generous space for readers' comments. Indeed, readers are invited and encouraged to participate in discussion of all matters dealt with in the journal.

In addition to publishing substantial articles of professional significance, the journal will include items of news, and notices of books, films, and other materials useful to professional workers.

In its small way, CHILDREN will carry forward a service that the Children's Bureau has attempted, throughout its lifetime, to provide to professional workers in many ways: through person to person contact, through advisory boards and conferences, and through print. That is, to be a catalyst in speeding up the processes of research and of practice out of which will some day come that "state of complete physical, mental, and social well-being" we crave for all children from conception to maturity.

The usefulness of this journal will depend upon how well it serves the needs of its readers. We will appreciate greatly leads from them to new, unique, or otherwise significant developments in programs and research for children. We count on them greatly to give us the kind of friendly criticism on which we can grow in effectiveness.

Martha M. Eliot

Chief
Children's Bureau

a distinguished obstetrician asks how more mothers can get better care in child-bearing, and offers, for discussion, one proposal

MATERNITY CARE LOOKS TO THE FUTURE

NICHOLSON J. EASTMAN, M. D.
Professor of Obstetrics, Johns Hopkins University School of Medicine

THE RECORD OF MATERNITY CARE during the past few decades has been one to evoke gratification and pride. But in this rapidly changing world, maternity care must anticipate the future if it is to continue to serve the best interests of womanhood.

The greatest problem which maternity care will face in the next decade is personnel. Even today there is cogent evidence pointing to a shortage of physicians. In the last 30 years the output of physicians has merely kept pace with the growth in population. Meantime, the demands for medical services have soared. The expansion of public health programs, of industrial medicine, of mental hospitals and of research, plus the pressure of military requirements, have reduced the number of actual practicing doctors, in relation to population, to a figure lower than it was either in 1940 or 1949. Even a cursory survey of our 7,000 hospitals will show that only a small minority can secure an adequate house staff; many have none whatsoever. According to a recent report of the Council on Medical Education and Hospitals of the American Medical Association, there are about 3,000 more approved internships in the United States today than there are interns. In a certain large municipal hospital, a fourth of the babies are born without benefit of medical attendance, simply because three lone interns cannot handle 4,000 deliveries a year.

The forecast for the future is still more worrisome. On the basis of an expected population of some 171,000,000 in 1960, the Commission on the Health Needs of the Nation predicted that 30,000 more physicians than the anticipated supply in 1960 will be required to give reasonably comprehensive care to the entire civilian population and to meet the pressing needs of the public health services, industrial medicine, mental and tuberculosis hospitals, faculties of medical and public health schools, and the armed forces.

In view of the dearth of physicians predicted for 1960, those interested in maternity care will note with concern that in the late 1960's a sharp rise in birth rate is probable. In the mid-forties any overworked obstetrician could have warned his Commissioner of Public Schools to expect a huge increase in first grade pupils around 1953; and exactly this has happened. By the late 1960's these same first graders will be reaching marriageable age and it can be forecast with reasonable certainty that the marriage bureaus of that decade will be just as overcrowded as are the school houses of today. This means of course more babies and more maternity work. Some idea of the extent of this increase may be visualized from the following figures; the number of young persons who will attain the age of 20 in the late 1960's will exceed by more than one-third those who are reaching that age during the present decade; the number of young persons who will reach their sixteenth birthday during the single year of 1963, it so happens, will exceed by more than two-thirds those who attained that age during the year of 1953.

But these are not the only factors to be considered in evaluating the future adequacy of maternity personnel. Of the number of doctors who will be avail-

able, what percentage will elect to practice obstetrics? Will the proportion be more or less than today, or perhaps about the same? Although this question cannot be answered with certainty, the evidence suggests that the percentage will not be more and may be less. Those of us who have given our lives to obstetrics and who list it high on the roster of essential medical services will admit with reluctance that it is not a popular specialty. But this is the truth. Many general practitioners will tell you that they continue obstetrical work solely because it engenders good family relationships and so contributes to the development of their practice in other fields. A surprising number of obstetric and gynecologic specialists, when they get to be about fifty, decide to "graduate" (so they say) into straight gynecology because of the long, irregular and unpredictable hours which obstetrics imposes. As the ranks in other specialties start to thin, can obstetrics still attract its present quota of practitioners? It is conceivable that this question may be answered in the negative.

Although the outlook for adequate obstetric personnel over the next decade is therefore discouraging, there is no reason for outright pessimism provided immediate steps are taken to meet the threat. Even if these dire forebodings do come to pass, it will not be the first time that obstetrics has faced a shortage of physicians. In World War II, as their younger colleagues went into uniform, a large number of obstetricians confronted the onus of delivering 700 and more babies a year. This means, on the average, two deliveries a day in addition to miscarriages. It means, on the average, one patient in labor all the time, day and night, 365 days of the year. When account is taken also of the irregular spacing of these deliveries plus the huge amount of prenatal and postnatal care entailed, the magnitude of the assignment would appear more than any one person could possibly manage. Nevertheless, it was managed and, by and large, managed safely.

How was it done? To the credit of these obstetricians let it not be forgotten that the most important factor was ceaseless work on their part to the point of physical collapse. But, another factor also proved indispensable and helped greatly to save the day: to wit, the assistance rendered by nurses trained to a certain extent in clinical obstetrics. After a suitable period of instruction these nurses were prepared to perform, if need be, the following functions: in prenatal care, history taking, blood pressure determinations, venipunctures, abdominal palpation, fetal heart observations and attention to the more common complaints such as nausea, heartburn, constipation and excessive weight gain; in labor, they were trained to carry out, in addition to the procedures just mentioned, rectal examinations, emotional support of the patient and, indeed, pretty much the entire conduct of labor except actual delivery. The latter they undertook only as an emergency. If, at any time, the slighest abnormality developed, the obstetrician was notified. Actual analysis of the case records of obstetricians who followed this pattern of maternity care, reveals that at the first visit, the patient was always examined and interviewed by the physician; on subsequent visits she was examined by the obstetrician once in every three visits perhaps but brief interviews might be more frequent. The number of examinations carried out by the physician

NATIONWIDE SHORTAGES of well-trained workers are reported in many professions serving mothers and children. More people are making more demands for such personal services. Techniques of care constantly become more complex. Increasing use of professional health and welfare personnel in administration, teaching, research, and Government adds to the pressure on supply.

What can be done to meet both present and prospective requirements for such workers? This is a question that gives pause to the thoughtful in all professions.

Here is one expression of concern and one proposal in the field of maternity care. It is presented without official endorsement by this publication or by the Children's Bureau, but in the conviction that any thoughtfully advanced method of meeting this need merits discussion.

As a forum for the exchange of professional opinion, CHILDREN invites its readers to share with each other, through the pages of this journal, their findings and their feelings about this and alternative proposals for resolving so important a national problem.

in the course of labor and the time he spent at the bedside varied with the exigencies of the moment.

This, then, is a program of maternity management in which the obstetrician relies heavily for the minutiae of care on specially trained maternity nurses. They act, as it were, as "obstetric assistants" and constitute an important part of a maternity team. It is an arrangement which has saved untold hours for obstetricians and which, in actual practice, has worked, and worked safely.

Questions will of course be raised about the dependability of these nurses' observations, both in prenatal care and in labor; but anyone with much experience in obstetrics will probably agree that the errors and oversights of such a nurse would be fewer in the long run than those of a hurried, harassed and exhausted obstetrician. In all likelihood they would be just as reliable as those of an intern, probably more so; but there will be no question of competition here with interns because, if the prognostications set forth in the first paragraphs of this article are correct, a huge number of hospitals will have no house staff.

If the utilization of skilled maternity nurses with advanced clinical training has proved helpful when obstetricians in private practice have been faced with a shortage of medical personnel, the same general principle would seem applicable to other areas of maternity care, for instance, to vast sections of the South where about one-half of the nonwhite births occur in the absence of either a physician or a nurse. But, at this juncture, let us be absolutely certain that this "general principle" is clearly understood. It entails the use of highly trained maternity nurses who ***work under the direction and control of an obstetrician.*** Any thought of resurrecting the independently operating midwife is out of the question. That is why the terms "Advanced Maternity Nurse" or "Obstetric Assistant," long and clumsy as they are, may be preferable to "Nurse-midwife." But, no matter what appellation is decided upon, the prerequisites to success of any such plan are (1) that a physician examine and screen all patients at the onset of prenatal care, and, through the nurse, assume indirect responsibility for such normal gravidae as are turned over to her; and (2) that the obstetrician, by a pre-arranged and well organized plan, be available for consultation throughout pregnancy, labor, and the puerperium. As for the workability of this plan in underdeveloped rural areas, a very similar program proved highly successful on the Eastern Shore of Maryland during World War II and, as everyone knows, this general arrangement constitutes the pattern of the Frontier Nursing Service whose record in certain isolated areas of Kentucky is enviable.

In both the Maryland and Kentucky programs, home delivery was the rule except in complicated cases. The concept of maternity care which is here envisaged for underdeveloped areas postulates hospital delivery by these specially trained nurses. That, at least, should be the goal because home delivery, quite apart from other drawbacks, is the most extravagant form of maternity care in its expenditure of personnel. Thus, a team of physicians and several maternity nurses can give continuous care during labor and delivery to many women in a hospital during the time demanded by a single labor at home. Moreover, from the viewpoint of the safety of mother and child, it is preferable that a patient be delivered in the hospital even though she has to be sent home within 12 hours. This idea of maternity nurses delivering babies in the hospital is a new one in the United States but is part and parcel of this program recommended to meet the shortage of physicians. The development of such programs should be a joint enterprise between the local health department, on the one hand, and the local medical society or university department of obstetrics and gynecology if available, on the other.

But attention to our own mothers is not the only responsibility of the United States in maternity care. As the bonds between free nations become closer, agencies throughout the world, especially in Asia, are beseeching us for advice and personnel to promote their own maternity programs. Since about three-fourths of the world's births occur in Asia, the magnitude of the challenge is staggering. Here again the chief need is personnel. At a meeting of the Expert Committee on Maternity Care of the World Health Organization, held at Geneva in November 1951, the global aspects of maternity care were discussed in detail and it was agreed that the overwhelming need was facilities for the training of native midwives. A pattern for maternity care, under the conditions existing in Asia, has been developed in China by Dr. Marion Yang on the basis of some forty midwifery schools scattered throughout the country. That experience has served to stress the essentiality of the midwife in all public health programs for underdeveloped areas. To a greater extent than any other public servant she enjoys the affection and confidence of the populace, has an entree to their homes and,

if properly taught, is our most efficacious agent in enlightening the masses in regard to the rudiments of general hygiene as well as maternity and child care. The World Health Organization is seeking American nurses with advanced maternity and public health experience to help organize schools for the training of native midwives throughout the world. It is American nurses who are sought for the purpose, not midwives in the ordinary sense of that word, because it is believed that a broad background in nursing, in public health, and in social outlook is essential. But to equip these young women for such service it is mandatory that they receive advanced training in maternity care. They must know practical obstetrics.

Although the potential openings for American nurses with advanced maternity training are thus legion, two questions at once pose themselves: Where can nurses who wish to embark on such careers obtain training in clinical obstetrics as part of a program in maternity nursing? Can the necessary number of nurses be recruited?

Opportunities for such training in obstetrics, as part of a program in advanced maternity nursing, are practically nil in the United States. To develop them will require fortitude, because the whole scheme is contrary to orthodox thinking in this country. It will demand patience, because this is a pioneering effort in which misunderstandings are likely to develop and in which trial and error, at the start at least, must be the policy. It will necessitate furthermore, on the part of most obstetricians and some nurses, a complete revision of their attitude toward the functions of the nurse in obstetrics. But, in the light of the personnel shortage facing maternity care, and our changing concepts of the kind and quality of care required, who can name a feasible alternative?

What sort of training program is contemplated? It goes without saying that all candidates must be graduate nurses, matriculated in advanced programs of maternity nursing. The duration of the course in obstetrics which is included in this comprehensive maternity nursing program should not be less than 6 months. It should be under the direction and control of the obstetric staff of the hospital and with the cooperation of the nursing group. The number of students should be limited to such an extent that each student conducts not less than 30 deliveries during the course. The program of training would resemble an internship in obstetrics with certain exceptions: (*a*) The clinical work would be complemented, especially during the first months, by intensive coverage of the whole field of practical obstetrics, especial emphasis being laid on prenatal care, the conduct of normal labor, and signs of the abnormal; (*b*) a number of procedures, such as forceps delivery and general anesthesia, would not be assigned to the students. In order to make the training as useful as possible, however, she should be instructed how to repair spontaneous lacerations, to perform episiotomy and repair, to administer pudendal block anesthesia and should be allowed, under "scrubbed supervision" to deliver a few multiparous breeches. Yes, much of this is contrary to established custom.

Since March 1953 an experiment has been under way at the Johns Hopkins Hospital the purpose of which is: (*a*) to study the feasibility of training nurse midwives in a university obstetric clinic; (*b*) to evaluate the specific contributions which well trained nurse midwives can make to maternity care; and (*c*) to ascertain the role which nurses so trained can most advantageously play on the obstetric team. The project is being carried out in cooperation with the Division of Nursing Education, Teachers College, Columbia University. The trainees have appointments as "obstetric assistants." This designation was chosen because it more nearly connotes than any other the main function which we would envisage for such nurses; namely, the rendering of skilled assistance to obstetricians. In vast rural areas of this country and in understaffed hospitals, this skilled assistance may also include the conduct of normal deliveries but never without the supervision and control in absentia, of a readily available obstetrician.

In the first 6 months 2 nurses were selected who had completed the course in Advanced Maternity Nursing at Teachers College, Columbia University and the course in Nurse-Midwifery at Maternity Center Association, New York City. These nurses gave complete antepartal, intrapartal, and postpartal care to 85 mothers, under the supervision of the obstetric staff. Our experience during this time was so gratifying in every respect that a 6 months' course was begun on October 15, 1953, for nurses who had completed the course in Advanced Maternity Nursing but who had not had previous midwifery training. The students receive instruction and guidance from the 2 obstetric assistants who continue to work under the supervision and control of the obstetric staff.

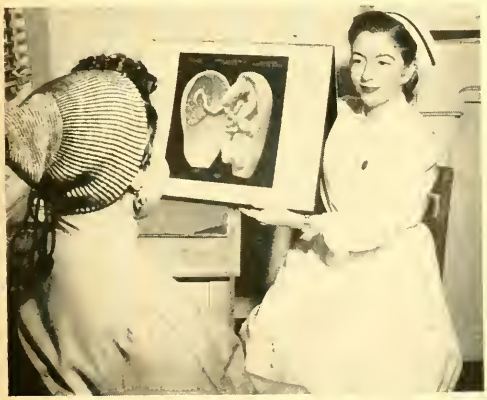
Although we still consider that this program is in the experimental stage and avow that we have

much yet to learn, we are convinced, on the basis of close observation, that nurses with this type of advanced training have unique and urgently needed contributions to make to maternity care. Quite apart from the expected shortage of physicians, mothers everywhere stand to benefit from the meticulous, sympathetic, and highly personalized attention which such nurses are able to render throughout pregnancy, labor, and the puerperium. By training, temperament, and outlook, they are singularly fitted for this important mission. This is their transcendent raison d'être.

The problem of recruiting a sufficient body of qualified nurses to make this project worthwhile, may or may not prove difficult; and limiting the group to eligible candidates from the advanced maternity nursing programs will involve less rapid expansion, but their competence will be recognized and the quality of care safeguarded. Despite this country's 365,000 active nurses, there is a critical shortage; and it is estimated by the President's Commission on the Health Needs of the Nation that the shortage for the country as a whole in 1960 may exceed 50,000. On the other hand, this figure means that the ratio of nurses to population in 1960 will be a little higher than we have at present. Moreover, the program envisioned for these maternity nurses offers such unique responsibilities and such rich opportunities in various spheres that it promises to attract a full quota of well prepared candidates. As in other clinical fields such as psychiatry, the profession of nursing will maintain its position by qualifying its members for increasing responsibilities.

Many other problems facing maternity care now and in the future will doubtless come to mind, but most of these center, in the last analysis, on this same crucial issue of personnel. For example, more hospital beds are urgently needed since ideal maternity care demands a 10-day hospital stay. To attain this objective in many localities, new hospital construction will be necessary; but in countless other areas, where the shortage of maternity beds may be equally dire, large maternity units are closed down because of insufficient professional personnel. There are plenty of beds, but no doctors or nurses. In this connection it is important to recall that the maternity nurses of the type we have in mind can function, if need be, as competent members of the clinical obstetric team as well as administrators, supervisors, or teachers, of maternity nursing care.

Dr. Eastman's "obstetric assistants" assume responsibility, under medical direction, for the care of a mother throughout her antepartal, intrapartal, and postpartal experience.



The most prevalent criticism which European obstetricians and midwives level at American maternity care is our assembly-line method of managing patients, especially the fact that they are often left alone throughout most of labor. This lapse is even cited as evidence in favor of home delivery. It is pointed out that parturients at home are never left alone and that they are amid familiar faces and surroundings with the result that apprehension is minimized; and, as apprehension is minimized, labor becomes more physiologic with a lower incidence of uterine inertia. There can be no question about the general validity of this criticism. The lesson to be drawn from it, however, is not that we should elect to go back to home deliveries but that the psychological advantages of home delivery should be brought to the hospital. This emphasizes again the need for the type of maternity nurse which we have visualized.

Given competent personnel in sufficient quality and quantity other problems dwindle in significance because such personnel can be counted on to resolve whatever other difficulties arise. The vast strides made in maternity care during the past few decades are attributable to many factors, but the transcendent factor has been a network of thoroughly trained obstetricians and nurses. This army of workers did not develop by chance but was the purposeful and far-sighted creation of various agencies intent on meeting the recent needs of maternity care. Let us hope that the crucial problem of future personnel will be handled with equal wisdom and success.

how do we train for

LEADERSHIP IN PARENT EDUCATION

GUNNAR DYBWAD, J. D.

Director, Child Study Association of America

IN HER PAMPHLET, Children Living in Their Own Homes,[1] Annie Lee Davis draws a challenging picture of the widening horizon of child welfare programs. In outlining social services that should be available in each community she stresses those insuring healthy growth and development in children, which are extended to parents before difficulties arise. While she includes many aspects of what is known as family life education, this article will review specifically her suggestion that child welfare agencies make it a staff function to organize and lead parent education groups.

This is not the first time a claim has been made by the welfare or health field that parent education groups may be considered a professional responsibility within its sphere. Family welfare agencies, neighborhood houses, hospitals, and public health nursing groups have demonstrated by their activities their interest in this area over a number of years and increasingly so within the very recent past.

It therefore seems appropriate to define what is meant by parent group education and to explore content and methodology as well as the added professional skills, if any, required for this activity.

The specific focus of this article is on parent education groups, using the discussion method, in which parents come together for a series of meetings. Such groups have been in existence since before the turn of the century. These first groups, while few in number, nonetheless had great significance because they represented an early recognition on the part of "just parents" that they had a need to learn more for themselves about the responsibilities of raising children. In the historical files of the Child Study Association of America are minutes of parent groups meeting in the 1890's which record in detail how they struggled by reading together and discussing Rousseau's Emile so that they might gain from his knowledge better understanding in coping with their problems as parents.

From those early beginnings parent groups have multiplied to the point where now there is hardly a town in this country that does not have one or more groups of parents meeting together for the specific purpose of learning more about their children. So great is the variety of auspices under which these groups meet that it is scarcely possible to arrive even at an approximate estimate of their number. Nor is this the only unknown factor, for these groups differ so substantially in their objectives that they cannot be characterized in common terms. Their variations today serve, in fact, to demonstrate the evolution of methods for such groups from the use of classical books as guides, to instructional lectures by experts, to the use of group discussions, and then, under the impact of dynamic psychology, to an increasing emphasis on the group process. All these approaches can still be found in use today.

In more recent decades, however, parents have also come together for other reasons than "child study." It is therefore important to state that for the purpose of this article the term parent discussion group will not include group efforts toward improved community conditions, or assessment of community needs, or those designed to interpret community programs to parents or to assist them to assume community jobs, all of which are of vital concern to the child welfare worker. Nor can this article consider the overwhelming number of parent discussion groups meeting under what has become known as lay-leadership, a term incorporating a wide range of types and degrees of competency, which naturally reflect on the groups' programs. These lay-lead groups constitute a major movement in this country,

PARENTS ARE TARGETS for many darts these days by lovers of scapegoats. It is time that more thought be given to how parents can be helped, rather than ticketed as failures. As managers of what Dr. Brock Chisholm has called "the biggest business in the world, the business which outweighs all other values: the rearing of children," parents as a group merit far more of a hand than they are now getting.

Programs of parent education increasingly are demonstrating their usefulness in deepening parent understanding of child behavior and in enriching parent-child relationships. This author sees many kinds of professional workers taking leadership in this movement, provided they have the requisite specialized training for this work. Here he emphasizes the possibilities for one group, the well-trained child welfare caseworker.

whose focus and method deserve careful evaluation. How agencies in the health or welfare field should relate themselves to them does not fall within the framework of this article.

In thus limiting this discussion to parent education groups meeting over a period of time under professional leadership we find that recent efforts to define this activity reflect confusion or at least sharp divergencies of opinion within the professional field.

In its pamphlet, Scope and Method of the Family Service Agency,[2] the Family Service Association of America speaks of (parent) group education as "activities in the interest of disseminating knowledge about human relationships and social adjustment." This seems to signify a didactic approach. Irving Brodsky [3] defines parent group education as "group counseling . . . a method of family life education which draws on the techniques of discussion leadership, to teach individuals in a group setting knowledge and skill in family relationships. . . . It is an educational process aimed not at treatment but prevention of disturbance in personality or family relationships."

However, in their paper Casework in Small Group Settings,[4] presented at the 1953 National Conference of Social Work, Grunwald and Greving define the term group counseling as "an application of casework methods within a group setting" with reference to a group of clients who have come to the agency for help with specific problems. Thus it appears that the word "counseling," which has been used to define social work activities in other contexts as well, does not serve to clarify the scope of parent group "education."

More helpful toward clarification have been efforts to crystallize distinguishing criteria by differentiating group education from group therapy.

Dr. Peter Neubauer has pointed out succinctly that group therapy directs itself to the deviant aspects of personality, the symptoms or the character disturbance, using a specific technique to effect a change in individual pathology. Group education, on the other hand, is oriented to the healthy factors of the personality with the goal of helping parents to gain an understanding of themselves and their children, and an increased capacity to make their own choices on the basis of such understanding. Thus group education is to be understood as a dynamic learning experience which goes far beyond intellectual absorption of new knowledge through a didactic process, since it actively involves the feelings and attitudes of the group members.

"Under skilled leadership, parents are helped to share their thinking and feeling about their common concerns, to examine the meaning of their common experience and to build on their inner strengths as they take on a more integrated parent role." [5]

A further clear methodological distinction lies in the fact that, in contrast to group therapy, parent group education does not aim to explore unconscious motivation nor to solve specific problems of a parent in the group, even though specific parents' experience will be utilized to focus on general concerns of the group. Each of these two approaches, group education and group therapy, has its own objective methods and procedures which can operate side by side in the same organization.

These necessarily brief comments on the nature of parent discussion groups point up why this is an area of function for the professionally trained leader. However, the existing confusion in the professional field as to the nature of parent group education is matched by a resistance on the part of some parents to recognize this need for professional leadership.

The Fact Finding Report of the Midcentury White House Conference, Personality in the Making,[6] has a revealing section, The Family and the Experts, which emphasizes the increasing number of new sources of help for young parents which replace or supplement such traditional advisors as the family doctor and the family friend. Many parents find themselves overwhelmed by the "expert" advice on parenthood and child rearing which is coming to them today through an ever-increasing number and wide range of channels, such as newspapers and magazines, television, parent teacher organizations, guidance counselors, well baby clinics, and community agencies. It was in recognition of this fact that the Child Study Association of America held its 1952 conference on the theme "Parents in Search of Self-Confidence." At this meeting, Dr. Frederick C. Redlich,[7] in a talk on Parents and Experts, emphasized the responsibility of the professional in his relations with parents, lest efforts at helping parents actually result in increased anxiety.

This is a significant point, particularly in considering its application to the professional leader's function in parent discussion groups. What in his knowledge has general applicability and where are the limits of his "authority"? Here again we find a divergence of prevailing opinion as to the degree of leader activity. One viewpoint from the family agency field sets forth as the leader's responsibility "to develop sound and generally accepted concepts of attitudes and behavior. . . . The discussion leader represents an ego ideal to the group and should embody accepted standards. The role of the leader is to be allied with the strivings toward meeting social demands." [8]

From the group work field comes the suggestion that the leader of such groups is the transmitter and interpreter of positive cultural ideals and values. This raises the query as to who determines these values and ideals and accepted standards. W. L. Kindelsperger, in discussing at the 1952 National Conference of Social Work some aspects of "new" leadership function in adult education, stated: "I sometimes suspect myself and other persons who are professionally concerned with group processes and leadership in that we may be subconsciously preoccupied in trying to find controlling positions from which we can work under democratic forms." This caution is particularly appropriate in a nation with such a wide range of ethnic and religious groups and a correspondingly great variation of cultural patterns. Indeed, it is this range of variation which makes it important in our country to have free discussion groups where parents do not meet an "authority" but rather a catalyst and interpreter who can help them to understand their children's developmental needs, to recognize their own goals as parents,

and to work out their own solutions from an awareness of existing differences, as well as similarities, in our society.

What kind of training, then, is indicated to prepare the child welfare worker for an assignment of leading a parent education group? Again, we find wide disparity of opinions. Some feel that "mature and experienced caseworkers can acquire the necessary knowledge and skills through supervised practice of this kind of work." [9]

Others feel that the one missing link in the caseworker's preparation is "some understanding of group dynamics as applied to methodology." [10]

Other suggestions add to this training in group dynamics a limited amount of "in-service training." This raises, of course, the question as to what is meant by this requirement of knowledge of group dynamics. Kindelsperger warns about the possible dangers of an overemphasis on techniques per se, stressing that the important new elements in the adult education field have become overshadowed by devices such as "listening roles," "feed-back," "buzz sessions," and "role playing." There is much evidence that such a development has taken place in the field of lay leadership of parent groups and there is sound basis for Dr. Kindelsperger's caution with regard to professional leaders as well. Group dynamics, indeed, has a major contribution to make, but it needs to be put into the context of the total job of the parent group leader.

Still thinking in terms of the caseworker, including the child welfare worker, primary consideration must be given to the worker's readiness to deal with the content of parent discussion groups. In the

light of our earlier statement, that parent discussion groups address themselves to the healthy aspects of personality, toward a better understanding of children's needs, within the setting of normal family living, we must ask to what extent such material is included in the training of caseworkers.

While all schools of social work provide for a sound introduction to the principles of mental hygiene, it has been the experience of the Child Study Association of America, in providing training as parent discussion group leaders for two successive groups of graduate social workers, that these trainees recognized the need for content additional to what material they could draw on from their professional training and experience. This is not surprising when one considers that in the setting of parent discussion groups, the leader must relate his material in a significant way always to the parent, who in turn will utilize what he gains by coming to a better understanding of, and more helpful relations with, his children.

The following are some areas in which the caseworker would need to have expanded knowledge in content:

1. The development of children in normal family living, with particular emphasis on the similarities and differences in their stages of growth and patterns of physical and personality development.

2. Awareness of the effect of parenthood on husband and wife individually and in their interrelationship.

3. Appreciation of factors making for mental health and a diagnostic awareness of them, since the basic goal of parent education is to build on strength in the individual parents.

4. Cultural factors affecting patterns of family living and the readiness of the parent objectively to review such patterns.

In addition to these considerations regarding content, two areas of methodology would require special preparation of the caseworker:

1. The new concepts of learning which have developed in recent years with reference to adults and which emphasize feelings and attitudes as much as intellectual ideas. Here, again, are some factors of particular import with regard to parents.

2. A knowledge of the dynamics of group process including the leader's role in helping the group to define and achieve its goals within the framework of the agency's program and purposes.

The foregoing refers to material which would appear in a training plan, on a lecture and seminar basis, as part of theoretical instruction. That this needs to be supplemented by field experience would appear obvious in the professional realm of social work which has always observed the closest integration between learning and doing. Fortunately, unlike either casework or group therapy, there does not exist the problem of confidentiality or delicate interpersonal relations to prevent observation of parent discussion groups by workers-in-training. As part of the step bridging the gap between theory and practice such observation has been part of the Child Study Association's training program for leaders of parent discussion groups for several years without objection from the parents, who are quick to accept the explanation of the reason for the presence of (silent!) observers. The opportunity of observing an ongoing group, from its first to its last meeting, gives the worker-in-training a live picture of the interaction of the group and leader as well as of the development of content by a specific group. Coupled with seminar discussions, it will go far to ease a worker, whose previous practice has been limited to individual contacts, into his first experience as a parent group leader. The trainee is then readier to go on to his field work and it hardly needs to be emphasized that this should be supervised experience.

This recital of desirable training requirements may appear too imposing and to some, perhaps, too exacting for as modest and as supplementary an assignment as the leading of parent groups would constitute in most agencies. But how else can we expect a worker to function in sufficient accord with this picture that Jerome Frank [11] draws of a parent group leader: "The role of the leader in a free discussion group is very different from that in a lecture or study group. He is less the authority and more the catalyst and interpreter of interaction between group members. His task is both to awaken and to shield the participants, to maintain a supportive neutrality with respect to all sides of an argument, to help members to focus on significant issues and fully explore their attitudes. The demands on his poise, sensitivity and skill in human relationships are great."

What has been said in this article about the need for special training for the child welfare worker doing parent education applies, with appropriate modifications, to other professions that work with parent groups. These include, among others, practitioners in other social work areas, psychologists, educators—including religious educators—and public

health nurses. Much further exploration is needed to determine to what extent training in those professional fields needs to be supplemented for adequate preparation for parent group education.

Parent group education is no panacea. While potentially it can do a far-reaching job in prevention, it is a professional service, as outlined here, and must be developed carefully with due regard to the availability of adequately prepared personnel. Still, it will make an increasing contribution to meet the challenge Annie Lee Davis puts forth in her pamphlet, Children Living in Their Own Homes:[1] "Present day knowledge of children's needs and good child rearing practices should be easily accessible to all parents and available in such a way that it becomes incorporated into their thinking and feeling. The all-important task of child rearing can no longer be left to chance."

[1] Davis, A. L.: Children living in their own homes. Children's Bureau Publication 339. Government Printing Office, Washington, D. C., 1953. 52 pp. (20 cents.)

[2] Family Service Association of America: Scope and methods of the family service agency. The Association (192 Lexington Avenue), New York, 1953.

[3] Brodsky, I.: Group counseling and school group work. The Group. February 1953.

[4] Neubauer, P., M. D.: The technique of parent group education. *In* Parent group education and leadership training. Child Study Association of America (345 East 46th Street), New York, 1953.

[5] Auerbach, A. B. and Goller, G.: The contribution of the professionally trained leader of parent discussion groups. Marriage and Family Living 15: 265–69. August 1953.

[6] Witmer, H. L. and Kotinsky, R.: Personality in the making; the fact finding report of the Midcentury White House Conference on Children and Youth. Harper, New York, 1952. 454 pp. (pp. 207–9).

[7] Redlich, F.: Parents and experts. Child Study. Summer 1952. pp. 10, 11, 29.

[8] Pollak, G. K.: Family life education; its focus and techniques. Social Casework 34: 198–204. May 1953.

[9] Taggart, A. D. and Scheidlinger, S.: Group therapy in a family service program. Social Casework 34: 378–85. November 1953.

[10] Meyer, M. S. and Power, E. J., Jr.: The family caseworker's contribution to parent education through the medium of the discussion group (Reprint). American Journal of Orthopsychiatry 23: 621–28. July 1953.

[11] Frank, J., M. D.: How parents learn. *In* Taking stock in parent education. Proceedings of the 1953 Conference for Workers in Parent Education. Child Study Association of America (345 East 46th Street), New York, 1953.

IN THE PERIODICALS

The December 1953 issue of ***Childhood Education*** is given over to "Children's Time." Among the many aspects of the subject considered are: the child's own concept of time, which is different from the adult's; the teacher's problem of how to use the child's time—"There never is enough of it. How can you be sure you are using it in the best way?"; and foreign comments on the characteristic American attitude toward time—"In America, everybody and everything seem to move as fast as they can." "People seem always to be in a hurry getting places and getting things done." But, surprisingly, "I could not trace impatience in the Americans despite the fact that they always seem to be in a hurry."

A study of maladjustment and maternal rejection in retrolental fibroplasia made at the Perkins Institution and Massachusetts School for the blind is reported in the October 1953 issue of ***Mental Hygiene.*** The authors found that: "Almost every rejected child was poorly adjusted. The converse also was true. All of the children whose mothers accepted them were well adjusted at school. Predictions regarding success or failure at school might have been made on the basis of whether or not children had been rejected at home; such a prediction would have been correct for fourteen of the fifteen children." The same issue carries articles on children's reactions to physical defects and on consultation service to public schools by a mental health team.

The UNESCO ***Courier*** for October 1953 is devoted to paintings and drawings by children. There are forty illustrations showing the work of children in Japan, China, India, Israel, Egypt, Nigeria, the Sudan, as well as half the nations of Europe and the Americas. The numerous articles include one by Henri Matisse on "Looking at life with the eyes of a child."

Scandinavian children's books are compared for quantity, appearance, and content with children's books sold in the United States and Great Britain in the Autumn 1953 issue of ***The American Scandinavian Review.*** "In proportion to population," the article states, "probably more children will receive more books in Sweden this year than in any other country in the world."

The ***Quarterly Review*** for October 1953 coutains an article on the role of the school in preventing juvenile delinquency. School organization, school attendance laws, class size, curriculum content and many other factors are considered in their effect on an adolescent's ability to find a socially acceptable place for himself in the world today.

Volume II, number 3, of ***World Theatre*** (published under the auspices of UNESCO) is devoted to the theater and youth. It is profusely illustrated with scenes from theatrical productions by or for children. The articles cover a variety of subjects, such as the children's theater in Great Britain, the theater for adolescents in Denmark, and creative and formal dramatics for school children.

In the summer of 1953 a camp for children 9 to 14 years of age was held at Imperia, on the Italian Riviera. The children represented 16 nationalities, 11 languages, and 6 religions. This camp is described in the November 1953 issue of ***Freedom and Union*** and the October issue of ***New Era.***

research into the behavior of a few holds promise of greater understanding of all children

CHILD STUDY IN A NEW SETTING

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IF ONE WERE TO MEASURE research accomplishments on the basis of a 24-hour day, he might well say the time is at least noon so far as the physical sciences are concerned, but it is still early morning in mankind's efforts to delve into the vast and intricate depths of his mental apparatus.

Any research which might possibly move us even a minute ahead in our understanding of the human mind and its effect on body processes, reactions and stimuli, is therefore potentially time gained, even though the hours still to be spanned may seem endless.

In this paper I would like to discuss the efforts now being made at the Clinical Center of the National Institutes of Health to budge time at least a few seconds ahead in our understanding of the human mind as it is reflected in the emotional disturbances of children.

Challenging is an overworked word, but it is certainly applicable to the task that faces those working on this project, still in its infancy at the Bethesda, Md., Medical Research Center.

The members of the staff, chosen for their particular aptitudes in working with children, had not only to decide upon the best methods to use to study and treat the children; in addition, from that vast body of what is not known, they had to choose those research goals which would meet the dual standard of reachability and vast application for others who work with children.

In these choices, we had to bear in mind the limitation which the setting of a large research hospital put upon us. Children can be decontaminated to a high degree from the feelings which a large hospital may produce in them. But the percentage of possible disinfection is not 100 percent.

To illustrate: a child with a physical upset, such as appendicitis, may react quite well to being hospitalized, because he knows hospitalization will make him better. But prolonged hospitalization, past the point where it can make a real contribution to his recovery, is fretful to him.

A child who is emotionally disturbed but who improves beyond a certain point should not live in a hospital ward. We recognize the need for an in-between in the course of treatment such as might be possible in cottage living, where the gap between psychiatric hospital and family or foster home in the community could be bridged.

Another consideration which went into our early planning was that the whole staff needed to be exposed to normal children, so that we would distinguish clearly behavior typical of an age group from behavior that is pathological.

For people who deal with disturbed children do have a tendency to focus on the pathology of disturbances, and to forget what is normal for a kid of a certain age. Anybody can legitimately be expected to be considered normal even though he has some peculiarities. Some adults, for instance, are afraid of mice. Some children have an irrational fear of the dark but still are normal children.

There was also the question, and a large one, of how much "trying out" we could do, once we had children with emotional disturbances as our patients. We thought it essential to "try out" a program with normal children, who, if we didn't hit it quite right, would tell us we were off. The healthy personality will defend itself against illegally high doses of boredom. If disturbed children were exposed to the same thing, they would get so disorganized it might be dangerous.

And so we arranged a trial run, before accepting any patients, to see what the research set-up looked like with children in it.

Physically, the ward is laid out around several general rooms, with living quarters arranged for two children to a room with bath. The general rooms include a large play or "day room" with tumbling mats, ping pong table, toys, books, radio, record player, and other devices. The lounge room has a television set. There is a room for arts and crafts, and for woodworking, and there are two schoolrooms. Apart from the ward itself, there is a sun deck, which can be used for roller skating, and a large gymnasium and auditorium, which is shared with the study patients in other research programs.

To try out this ward, we borrowed children for 2-week periods from an elemenary school in the neighborhood, and from welfare institutions. We asked them to come for a 2-week stretch of "camping," live on the ward, and tell us what the place should be like. We told them it would later be a hospital, and we wanted their advice on what toys and activities should be planned so that when children came as patients, they would have a good time.

These "research volunteers," as we called them, came in groups of from 8 to 12 for 2-week periods. We took both boys and girls, ranging in age from 6 to 14, and from different racial groups.

It was important to make our "research volunteers" see the "camping" as a 2-week interlude with a definite ending time. But even though both those who sent the children and the staff on the ward went to great effort to explain this, the children showed a disappointment reaction when they left which was out of focus with their verbalized acceptance of the short duration of the "camping." Some of them reacted by hanging onto doorknobs, hanging back when it was time to go.

It was interesting to watch the ways by which these children acted out their reaction to the hospital atmosphere. The first group of normal girls started their play activity by bandaging themselves, so as to shock their mothers when they came visiting. The hospital atmosphere seemed to provoke this or some other form of acting out, despite the fact that none of the staff was in uniform, and we avoided all semblance of a hospital in the ward itself.

Indeed, our staff members, for the period of the "try-out," laid aside their professional identifications. Instead of psychiatrists, psychologists, nurses or attendants, they became counselors, working together in teams. They were exposed to the different age ranges of children and were able to discuss freely with each other their observations as the program was developed.

The program was planned by the staff in a council meeting with the children, who made suggestions on daily routine and special activities, and whose reactions to what had gone before were welcomed.

On the basis of our trial run, we were then ready to accept our first patients. We had a staff equipped to handle up to ten disturbed children at a time, numerically large enough to have four supervisory people on the ward at all times. This includes psychiatrists, research psychologists, a teacher, a caseworker, a group worker, and members of the nursing staff.

The disturbed children who come to us may be referred by physicians, clinics, social agencies, from anywhere in the United States, although in these beginning months, we are limiting our patients to the nearby area. As do other programs in the clinical center, we attempt to give our patients maximum study and treatment within the limits of what is known during their stay at the Center. The Public Health Service's center for medical research provides the seven national institutes of health—mental health, neurological diseases and blindness, cancer, heart, dental research, microbiology, and arthritis and metabolic diseases—with resources for both laboratory and clinical investigation of the important diseases of today.

In our first studies, we are attempting diagnosis and treatment of children with extreme aggressive and destructive tendencies; children who, although in apparent physical health, have, by their attempts to act out their aggressions or their problems, been frequently hard to care for in the normal community life or in an institutional setting.

We start with the basic premise that not everything is wrong with these children. It is part of our job, and an important part, to assess what is right with them, and with this knowledge, attempt to find out what kind of treatment they respond to best. Our findings will go back to the referring physician who will work with these children when they return to their home communities.

In addition to the activity programs which our "research volunteers" helped us formulate, the children now at the Center as patients have a daily interview hour with a psychiatrist, who takes an active part in the ward life. Most of the children are

getting academic coaching on a "remedial" basis or attending regular classes at the center.

Our experience so far has shown us that there may be definite value in what might be called the "marginal interview." The psychiatrist who is giving individual therapy to a disturbed youngster may see him only during a regular weekly visit, and may find him unresponsive during the normal treatment period.

Youngsters, especially those at an early adolescent age, may find the idea of sitting in a room and talking to an adult about their problems quite unbearable. But many of these children are quite capable of revealing by their play activity what is going on inside them. They may find it quite natural to talk to an adult about things which happened in a game just finished while they are still "hot." They may have a blowup, a temper tantrum, which they are perfectly willing to talk about when it happens, but which might be forgotten by the time their regular weekly interview comes around.

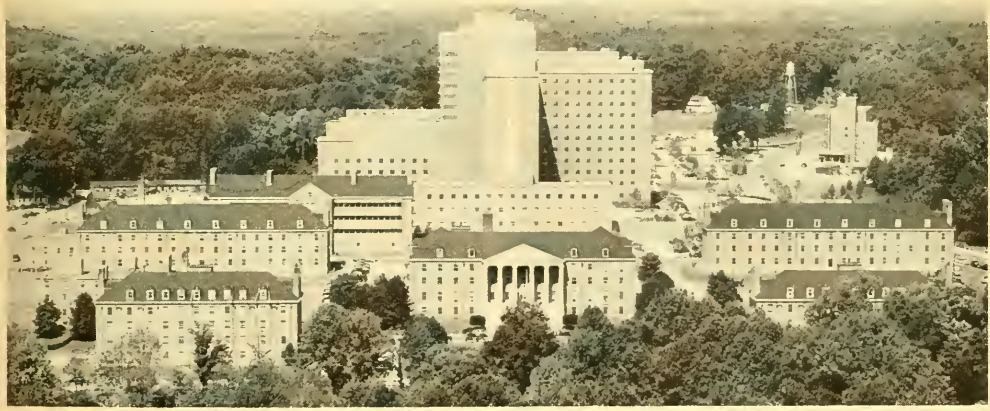
At the Center, our psychiatrists can take advantage of this "marginal interview" opportunity when a youngster exhibits some unusual behavior or shows some upset, either in play activity or at some other time. The timing, in talking about things just after they happen, seems to be very important.

As mentioned earlier, in discussing research goals, we attempted to choose those which seemed reachable and widely applicable. We are presently concentrating on finding the answers to four questions which we believe meet these criteria:

1. Can children work out their problems through arts and crafts, day dreams, fantasy, or do they have to act them out in reality? Some youngsters can use a revenge fantasy; others have to bite, hit, kick, throw things at anyone at hand, even though that person has nothing to do with their frustrations. For one boy, even the mild physical discomfort of a sore throat will bring on an attack on adults who "made my throat sore for me."

2. What is the nature of group excitement that causes loss of controls? It seems important for practitioners, both teachers and parents, to know how controls in children are developed, and how they can be cemented against breakdown under stimuli. Many children—both those normal and those who are disturbed—have a reasonable amount of control over their emotions and impulses, and can be considered well integrated in this regard. Some, when exposed to excited group situations where everybody else begins to act wild, lose all sense of proportion. Their ego controls melt like a chocolate bar in the hot sun.

"Symbol of man's untiring search for knowledge and a better life," the Public Health Service's Clinical Center towers above the buildings that house PHS's 7 research institutes, all of them located at Bethesda, Md., a suburb of Washington, D. C. Dedicated on July 2, 1953, the Center provides 500 beds and double that amount of space for laboratory work in basic and clinical research into major types of illness. Dr. Redl's headquarters are on the fourth floor.



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This form of "group psychological intoxication" is comparable to the way adults may act when they go to a convention in somebody else's town. It is important to understand the factors which loosen or negate the control mechanism.

3. What happens to adults when they are exposed to the behavior of disturbed children? One skill which the teacher, the child worker, and the parent need is the ability to cope with the emotions and anxieties which are created in them by exposure to disorganized behavior in a child. What experiences in the adult's own life predispose him most favorably to work skillfully with children, of what ages? This becomes especially important when advising an individual on the choice of his professional career. It is also important in the choice of that person with the best professional equipment for work with a given kind of child in a given age range.

4. What children benefit from "treatment homes"? Over the last decade, interest of communities in developing "treatment homes" for children with severe behavior disturbances has grown by leaps and bounds. Yet little is known about which children benefit most from such arrangements. The possibilities of observation which the clinical setting offers should help us to develop more conclusive criteria for referral to treatment homes than we now possess.

When we arrive at findings in these four areas, we will have added a little to the skimpy body of scientific knowledge on the treatment of disturbed children. But for every question answered, a dozen unanswered questions turn up, like dragon's teeth, to plague us.

I would like to mention a few areas—although by no means an inclusive list of them—where there is demonstrated need for research.

We know relatively little about ego disturbances, about children with terrific control breakdowns.

We have not isolated the influence technique, the degree to which an adult can handle a problem child skillfully by the way in which he does things to or for the child.

All pictures of children on these pages were posed by members of the Center staff and their families in typical clinical situations. Dr. Redl and the child of a staff member have the kind of private chat that would take place between a psychiatrist and an emotionally disturbed patient.

Children under treatment at the Center are not separated from staff members even at mealtime. At least one staff member sits at each table. Meals are carefully planned under supervision of a nutritionist. The window in the background, not used for observation, opens from the nurses' station.

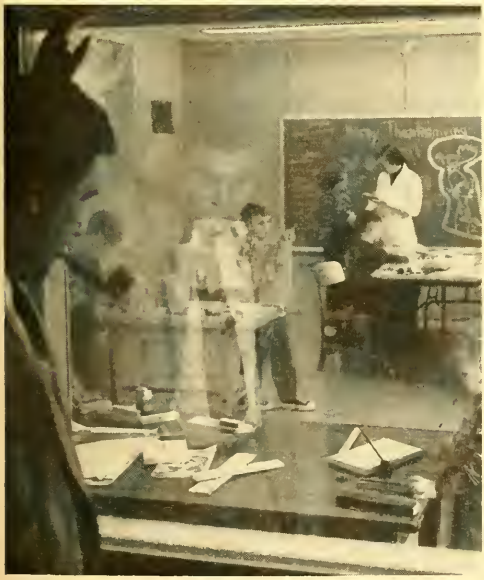
We know less about extreme aggressive behavior in children than we do about anxiety neuroses. This kind of behavior often eludes study because people experience so much difficulty in living with an aggressive child. One of the most neglected aspects of normality is the study of the amount of aggression which a child may need in order to survive in the community and under the cultural demands in which he lives.

Politeness, as an example, is a characteristic which has quite different meaning in different subcultural classes. I remember life in a rather fancy boarding school where I was puzzled by the amount of politeness which some of these youngsters threw at me. Whenever I came to the dining room, they would line up, yank open the door and let me float in like the Prince of Wales, offering me on a platter the kind of automatic respect which otherwise one would not expect to get without battling for it heavily. In this case, hyper-politeness was meant as a compliment related to the caste and class difference between the children themselves and the teachers.

Switching from there to a camp with rather aggressive youngsters from tough and disorganized neighborhoods, the phenomenon of politeness assumed an entirely different meaning. For those youngsters, being polite meant "That's the way you treat a guy you don't trust." You are polite to an enemy. To the degree to which one is acceptable, he doesn't have to run around in a psychological tuxedo all day long.

To continue with the areas where research is needed, we do not know enough about the impact of toys, games, and activities on children. Many ordinary children's games have the mechanics of wisdom built into them. Children who play them can discharge a certain amount of aggression without feeling guilty. The game "code" takes care of the excitement, without letting the activity get out of hand. In circle, running, and chasing games, some youngsters who come from tougher backgrounds have trouble, at the start, because the idea of being

One-way glass permits staff members free observation of the children in the classroom, at play, and as they work in arts and crafts. The children are told the glass is one-way, but are not told when they are being observed. These play-acting children seem undisturbed by their observer.



Disturbed children often are unwilling or unable to talk over their problems in a formal interview with a psychiatrist. Both to observe, from their play, what is going on inside these children and to be on hand when sudden blow-ups make talking easier, the staff takes part in all group activities.

chased by another child without retaliating immediately is equivalent to losing face with the group.

On the other hand, some anxious children can afford to express some mild aggression in such games without the fear of retaliation because the game "code" demands that one be a good sport. This is why most games have a "safe" place to which players can return with impunity when they become either too anxious or too excited to go on.

But we do not know which daily diet of activity program is healthiest and which, when engaged in even for the time being, may lead to overexcitement, breakdown, and confusion.

Yet it should be possible to select game materials for disturbed children so as to bring about better balance in the child's total life experience, without the risk of overstimulation or distortion of that experience.

We need to know how to differentiate more carefully between what is neurotic or schizophrenic behavior in a child and what looks like such behavior but is age-typical. Behavior that is in line with the developmental phase of the child's growth and is age-typical need not concern us. For instance, almost all children crawl on all fours at one age, but nobody gets excited about it.

We need to develop better criteria for predicting in earlier years the problems which may occur later. We need to differentiate between the things kids do which have no latent significance and others which may be called "cute" at one age but may be the beginning of later difficulties.

We need to clarify the connection between emotional disturbance and the learning process. At the present time, we have often made this an either-or business. Either we concentrate on the child who is emotionally disturbed, and try to straighten him out with remedial learning aids, or we concentrate on remedial education and ignore the emotional disturbance. It would appear that there is a submerged relationship between these two factors, and the attack on them may have to happen on both sides simultaneously.

Also unexplored is the question of how a group should be formed for therapeutic purposes. Which children should be put together in a given group at a given time? Quite often the behavior of some children is so overexciting or anxiety-raising for the others that their presence in the same group actually jeopardizes the treatment of everybody else.

On the other hand, quite often children supplement each other quite supportively, once they are well into a group, and they can function with much less disturbance than the history of any of them would have led us to expect.

In suggesting these areas for research into the pathology of the disturbed child, it is well to remember that the normal is also important.

So many people consider it unnecessary to do anything once a given piece of behavior is declared normal. This is quite out of line with the state we have reached in medicine. A tonsillectomy is considered to be rather a normal experience in a child's life, yet we would not relegate it to a person who is not trained to do it; we would not consider it silly to protect the person against damage or infection while he goes through it.

The fact that we consider such handling of a problem still a normal problem does not have anything to do with how seriously the problem should be taken, how much attention it should get, or what quality that attention should be.

In the field of human behavior, we don't seem to have reached an equal state of reality awareness. Very often by labeling something abnormal, we think we have to sail at it with all our forces, and by labeling something normal, we think it now isn't important anymore, that it is silly to pay any attention to it. In this way we are missing some of our most important therapeutic, as well as preventive, opportunities.

Uniforms are worn by none of the staff. Here a psychiatric nurse and two children inspect the aquarium in the children's ward.

Among the youngest of the health professions, medical social work has been one of the most persistent of all in evaluating its practices, examining its directions, and emphasizing its relationships with other members of a professional team. Large credit for this must go to the author whose past studies have been milestones in the development of social work.

PERSPECTIVES IN PUBLIC HEALTH SOCIAL WORK

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THE TIME HAS COME when public health social work needs to be examined from the perspective of the past, the present, and the future.

It will be recalled that in the late 1930's medical social workers as a professional group had completed their exploration of the hospital setting and had clearly defined social casework as the central function of the hospital social service department. Barely had this step been taken when new trends created new issues and carried us into a new cycle of professional development. The two major factors in this seem to have been psychosomatic medicine, with its deepened understanding of the individual patient, and public health programs, with their emphasis on service to large population groups. Both developments stressed multidiscipline activity and made it imperative for medical social workers to redefine their contribution. At the same time social work as a whole, previously focused on social casework and divided into many specialties, was moving toward a more comprehensive, unified, basic professional approach.

Thus, about 17 years ago, medical social workers were being drawn out of hospitals into broad programs where they had to face new situations, learning and exploring as they went along. From our present perspective, we can see that the situation was far more complex than we then realized. Alternatives had to be faced and judgments made at a time when principles were not clear. It is my impression that we are just beginning to arrive at the point where we can see the rationale and obtain more control in this rapidly changing situation.

The significance of our successive efforts to explore, analyze, and evaluate public health social work can now be better assessed. In the first phase we recognized that we had to move beyond social casework but we were aware that this still had an important place in public health social work. Thus the early movement toward "consultation" is understandable and important. The first attempt at a detailed analysis of functions and processes, undertaken by a study committee of the American Association of Medical Social Workers between 1946 and 1951,[1] could not get as far as we hoped toward clarification of function but was a valuable contribution. The analysis was sound in showing the full range of the medical social worker's activities more clearly than had been seen in the hospital situation. It enabled us to grasp more intelligently the comprehensive nature of the service and the total picture of what medical social work might bring to a health program.

The next effort to analyze public health social work was undertaken under the auspices of the United States Children's Bureau. This came about as the result of many years of joint thinking between Federal and State medical social consultants, culminating in an intensive workshop held in Washington in June 1951. The report which grew out of this workshop, Medical Social Services for Children,[2] represents a very real advance and clarification of our thinking. This analysis enables us to visualize all the activities as part of one professional job, to see medical social work as a whole. Social work texts traditionally devote one chapter to each field or process, discussing medical social work primarily as a form of social casework. In this newest report on public health social work the various

functions and processes are discussed with equal emphasis and with the implication that the social worker has alternatives in building the total job. In other words, the worker is not just a caseworker but a social worker in the broadest sense.

I had the opportunity of participating in the preparation of this report and wish to speak of some of the values which seem to me to have emerged, also some of the further advances in thinking.

In connection with this report, I would like to call attention to our social work tendency to think predominantly in terms of professional processes, such as casework and consultation. We have seen casework as central in social work and have worked out basic social work concepts and skills through this medium. Recently a similar process has been taking place through consultation. This method of professional thinking has been useful but can become limiting and even confusing. It is my own feeling that it is now too narrow and may lead us off the track unless it is more broadly focused and related to the concept of social work as a whole.

Several experiences have influenced my present thinking. As a result of participating in a study of social work education,[3] I have learned to look at social work more objectively and to ask myself constantly why we are doing what we do. Through our efforts to revitalize the study of our practice under the Practice Committee of the American Association of Medical Social Workers, and with the newer insights gained from current research methods I have been further impressed with the need to watch our assumptions, and to go very carefully and simply in our thinking. Finally, in working recently at the Simmons College School of Social Work on a student research project, I experienced the practical application of such disciplined thinking.

In this student project, which had to do with casework and consultation in a group of selected cases, we tried to describe what was going on, without hidden assumptions or special lingo. Because we felt our concept of "consultation" was not sufficiently precise, we decided not to use it. It seems that, although the public health social worker is customarily called a "consultant," she appropriately gives many other services than consultation as a part of her total job. Therefore, to avoid confusion, we decided to start with straightforward questions about the worker's activity such as: When was she working with patients? When with other professional persons? What was the purpose of one or the other type of activity? Finding the answer to such apparently simple questions required very careful analysis of the material. We found much movement from one emphasis to another within one situation. We also observed that very often in the traditional type of case recording, when a worker records contacts with other health and welfare workers the record reads much the same, whether she is doing casework or consultation. In her own mind the worker knows which she is doing, but the reader of the record can not tell. In other words, we need to bring out much more clearly what approach the worker decided to emphasize, what factors influenced this decision, and whether a new approach was made during the ongoing situation.

Thus my present feeling is that, if we are to clarify our thinking, we must start farther back than process. In each situation we must first answer the question as to what we are trying to do, what needs are we trying to meet, before we can get at the ***how*** of the activity. That is, ***purpose*** and ***function*** must come before ***process.***

This fresh approach suggests that what we have here is a new kind of diagnostic thinking. As consultants we face wider alternatives in choice of focus, approach, and process, than we formerly did as caseworkers. I would like to discuss some tentative suggestions which it seems to me might be helpful at this stage of our work and in this connection. They are the result of some very hard thinking on my part in recent months. It is not easy to see one's way through these complex issues.

Emphasis on Program Development

First I went back to this initial question about ***what*** the social worker in public health is trying to do. What are the objectives? What is the content, the meat of the work? Here several ideas flowed together from different directions.

A point that has seemed important to me ever since I worked at the Children's Bureau some years ago, recurred to me; namely, that it is essential that we define the principles of well rounded health and medical care programs, as developed jointly by the Bureau and the States, since many of the peculiar characteristics of public health social work are due to the fact that it has emerged from broad, socially oriented health and medical care programs of this type. I feel that we cannot understand the one until we understand the other.

I also recalled something Gordon Hamilton had said at the meeting of the Council on Social Work Education at St. Louis in 1953. Contrasting the typical American and European approaches, she said that we in this country tend to stress the professional process while they tend to stress meeting needs through a program of services, not individualized. I have thought a great deal about this relation between program and process, and it became more meaningful to me when Frances Heald was presenting her work to my class at Simmons last spring. She brought out clearly how the public health social worker, even when working on an individual case, is always aware of all the other individuals with similar problems back of the one patient, and how she is constantly thinking of their need of services and of the gaps in community resources. Thus the public health social worker's focus and choice of activity is influenced by the fact that she is part of a broad program involving large numbers of people, where there is concern for the rights of all, for service to all, and for the preventive approach. This constant awareness gives the individual patient a different significance than he has in the hospital. There, the casework focus is primary, though there is also an awareness of the broader group of services surrounding it. In public health social work the consultant's objective is always services to individuals, but the emphasis is, appropriately, more on development of program, on building a program of services to people.

I am wondering if it may not help us as medical social consultants in public health if, each time we face a decision about an activity in a specific situation, we think first about what we are trying to do in long range program development, and in this light decide whether to focus on the case, or the policy, or the other worker. Having thought about purpose, we might then arrive at a choice of professional process.

Let me illustrate how such decisions seem to be made from two brief instances.

The first situation, used by Frances Heald in interpreting public health social work to my students, began with the referral of a premature infant discharged from a small local hospital, lacking a medical social worker. The public health social worker made a home visit and discussed, with the parents, their anxiety and confusion regarding the problem of payment for the baby's care. It so happened that this was the first such problem to arise in that locality since the passage of new State legislation regarding the care of premature infants. This case showed that policies and procedures under the new program were not understood by professional personnel in the hospital and in the community. Therefore the next step, carried through in collaboration with the District Health Officer and the Nursing Supervisor, was to arrange a conference at the local hospital, which was attended by all professional workers (the hospital administrator, local health department nurse, and others) concerned with this case or likely to be concerned with similar cases in the future. After deciding what should be done about the particular case in question, the discussion moved out into a consideration of the program as a whole and the meeting ended with a series of agreements regarding policy and procedure. At a third stage the local health department nurse, who would carry considerable responsibility for working with families in the future, sought a consultation interview with the public health social worker to clarify her thinking regarding some of the social implications of the new program and her approach to parents in helping them to understand it. Thus the public health social worker moved through three definite stages in which her focus and method (1) began as direct social casework, (2) enlarged to participation in policy formulation, and (3) ended as consultative service to another professional associate.

The second illustration, which I used recently in my own teaching, is from a casebook prepared for an institute for medical social teachers in 1948.[4] It begins with a consultation interview between a public health nurse and public health social worker regarding a child with an orthopedic handicap, who after long care in a hospital was suddenly discharged home to a family obviously unprepared to receive him. In helping the nurse to consider what might be done about the urgent problems of this child and family, the public health social worker became aware of the broader problem of hospital discharge policy so starkly illustrated in this situation. As a next step, therefore, she took this problem to the director of her program, asking that it be discussed in staff meeting, to which he agreed. At the meeting the various members of the public health team discussed the problem of local hospital discharge policies from their various angles and agreed what action each would take in exploring the problem and dealing with it. Thus in this situation the public health social worker (1) began with con-

sultative service to the local public health nurse, (2) moved next into an administrative conference with the program director, which led to (3) a multidiscipline meeting with good professional teamwork on a policy problem, eventuating in (4) action on a phase of a local community program by the public health social worker and her associates.

In these illustrations it should be noted how several processes are used successively by the public health social worker in the ongoing situation, which we recognize as having logical continuity. There is no break in the movement from one stage to the next. Consultation is appropriately used in relation to a number of other professional processes, all of which become greatly clarified when related to the social worker's changing and developing purposes.

Some Key Questions

In thinking further about these decisions that public health social workers must make in specific situations, I felt it would help if we could get at some of the key questions that have to be asked and answered. Too, frequently, they are answered only by implication and it would be better at this stage, if we really wish to define our functions, to answer them directly and consciously. Again I tried to get away from the old question of "casework versus consultation" and to use a fresh orientation. I worked on this with my Simmons class and we found that it helped to think of different programs—such as Crippled Children's Services, Vocational Rehabilitation, and Public Welfare—because sometimes the very nature of the program indicates the answer to one or another question.

The following are some of the possible questions, and they go in pairs:

1. How much of my work shall focus on case situations? and

How much shall be carried out through broader phases of the program, such as policies, community resources, education and research?

It should be noted that this question refers to any type of work with cases, not just casework.

2. Whatever the focus, shall I directly participate myself; that is, be active, take responsibility, in the situation? or

Shall I work only through other professional and lay persons?

The second alternative, not to participate directly but to work through others, represents "consultation" as we now think of it.

3. When shall I stress service by means of direct relationship with individuals served? and

When shall I stress service by means of relationship with other professional persons?

The final pair are questions which we are asking in the Practice Committee of the American Association of Medical Social Workers. This pair overlaps the first two mentioned above but is different in its implication. One can work on case situations without direct relation with the patient. One can work actively with other professional persons in a teamwork relationship or restrict oneself to a consultative relationship. The preposition ***with*** covers all types of participatory working relationships with professional associates. The preposition ***through*** seems to refer specifically to the inactive, consultative role.

I do not wish to say that these are the basic questions we shall finally arrive at, but I do want to suggest that this type of question-and-answer, simply phrased but actually penetrating in its implication, is needed if we are to understand what decisions public health social workers are making and why they are making them.

Implications for Recording

It will be recognized that there are important implications here for methods of recording. For further progress, it is evident that professional records must include more material showing the worker's purpose, decision, and methods, at various stages of a situation. Conscious recognition by the worker of these major elements in the moving situation is essential for ongoing professional study.

I wish to make clear that the kind of recording to which I am referring is not necessarily the daily record of the agency. It is a special type, very carefully and fully prepared, for purposes of (1) clarifying functions and processes and (2) providing material absolutely indispensable for teaching. It is highly selective. What is needed is quality rather than quantity. If each public health social worker prepared just one such record a year, we should have made an important beginning. The small nucleus of this type of recording which has so far been demonstrated is already of very great professional value in both practice and teaching.

Relation between Professional Activities

There remain some additional key questions of a slightly different type, which are increasingly con-

cerning me and which I believe should be included in this discussion. They take us beyond the decision in specific situations to the ***total job.***

We must ask ourselves: ***What is the nature of the relationship between the worker's various activities? What principles define this interrelationship?***

The recent report prepared under Children's Bureau auspices discusses the medical social work functions one by one, and implies that they are combined in one job, but does not attempt to say how. This takes us back to Gordon Hamilton's point, but we should note an important difference. She spoke of emphasis in Europe on ***program without individualization.*** In our public health social work we see the program emphasis as including social work, that is, the professional process is integrated with the program. I feel that criteria for relating the various activities will emerge as we clarify the purposes and decisions made by consultants in planning their work. One very important aspect, as we are all aware, is the relation of casework to other activities. In the hospital, casework is clearly central but in public health, particularly at the consultant level of functioning, the answer is not so simple. I am convinced that an essential step, which all social work must take, is to relate casework (with all it represents in basic knowledge, skills and philosophy) more clearly to the rest of social work. My own hypothesis is that this relation is basic to the nature of social work, which moves out from and back to the individual.

Thus my questions, based on observation in the hospital, are these:

1. When we are working with and through other professional personnel, is it necessary for them to see the individual service demonstrated in order to incorporate the social work viewpoint and use social work appropriately in administrative planning, clinical service, teaching, and research?

2. In carrying these various broader functions of an administrative, consultative and educational nature, we ourselves certainly must have a base of casework knowledge and skill. Is it enough if the worker has had it in the past? Does casework practice have to be strongly imbedded in our program, possibly at times even in our own current professional activity, in order to maintain the depth, validity, and effectiveness of other activities such as consultation?

We cannot give the answers yet, but I believe it is extremely important for the future of public health social work that these questions be asked and answered. It appears that the interdependence of casework and program-building, whether through consultation or whatever channel, will be found to be vital and must be better understood for real progress in our work.

I would like to end on a note given in the final paragraph of the Children's Bureau report, which says: "A developing profession in a developing field must experiment and study. Out of such experimentation and study will come growth in practice and in turn, better service to people." I want to add that the effort of the small group of medical social workers in public health has been truly a pioneer service, out of which is coming much that is of very great value for the entire field of medical social work, and even further, for the profession of social work as a whole.

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[1] American Association of Medical Social Workers: Report of study of medical social activities in public programs. Washington, D. C., 1951. (Mimeographed.)

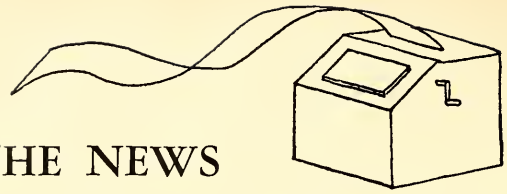
[2] Children's Bureau, Department of Health, Education, and Welfare: Medical social services for children in the maternal and child health and crippled children's programs. Washington, D. C., 1953. (20 cents.)

[3] Hollis, Ernest V., and Taylor, Alice L.: Social work education in the United States. Columbia University Press, New York, 1951.

[4] University of Illinois, Division of Services for Crippled Children: Medical social activities in public health and medical care programs. Prepared for the Institute for Medical Social Instructors. Chicago, 1948. pp. 66–67. (Mimeographed.)

"As well might one try to pick up a man's shadow and carry it away as to treat his physical ills by themselves without knowledge of the habits that so often help to make him sick and the character of which these habits are the fruit."

RICHARD C. CABOT, M. D.
in *Social Service and the Art of Healing*, 1917.



IN THE NEWS

From public and private sources IN THE NEWS gathers items for our readers' notebooks, speeches, or articles, on data or viewpoints in the fields of child health and welfare. The viewpoints are those of the person quoted, and not necessarily of the Children's Bureau. CHILDREN welcomes comments of readers on the value of "In the News."

More than half the country's 19 million working women are married, and 27 percent of all married women held jobs in 1953, according to a report by the Women's Bureau of the Labor Department. The report cites a "substantial" increase in wage rates for many kinds of women workers during the postwar period, but the median income rose only slightly, from $901 in 1945 to $1,045 in 1951. Median income for men rose from $1,800 in 1945 to about $3,000 in 1951 ● ● ● The statistically average mother in the United States bears her last child at the age of 27, according to 1940 U. S. Bureau of the Census figures.

Within the next decade, many teenagers will no longer be able to benefit from baby-sitting jobs, the Institute of Life Insurance predicts. The increase in the teen-age population has been interpreted by the Institute to mean there will be fewer baby-sitting jobs to go around ● ● ● "Bronxville Families Agree" is the title of an eight-page pamphlet recently published in Bronxville, N. Y. The pamphlet, which deals with "out of school" behavior, is the result of efforts of a group of parents in Westchester County to agree on standards of social behavior to which they, as individual parents, will adhere in dealing with their youngsters. The booklet has been distributed through the school system to all parents with boys and girls enrolled in the 7th through the 12th grade classes of the Bronxville public schools.

Among the 1,100,000 men turning 18½ years of age annually, 30 percent are rejected for military service for all reasons, including physical, mental, psychiatric, neurological and moral, according to the U. S. Office of Selective Service ● ● ● As of July 1, 1952, Census Bureau estimates are that there were a total of 15,049,000 teen-agers in the United States (children between the ages of 13 and 19, inclusive). In the 20–24 age group, inclusive, there were 10,597,000 persons, according to the census estimates ● ● ● A "charter" containing a basic "statement of social principles" on family life is in first steps of preparation by the Family Service Association of America. A Committee on Public Issues of that Association will study those issues it believes to be "most urgent" concerns of family welfare ● ● ● Legislation recently enacted by the Philippine Government makes it compulsory for all children to remain in school until they have completed an elementary education ● ● ● Rates charged by general hospitals increased about 6 percent during 1953, the smallest annual increase in rates since 1949, the American Hospital Association reports. The Association based its figures on 2,563 questionnaires filled out by general hospitals. Rate figures covered all meals, including general or special diets, general nursing service and, in more than 60 percent of the larger hospitals, the cost of routine drugs ● ● ● Some misconceptions about health were revealed in a public opinion survey reported on at the annual meeting of the American School Health Association. The survey showed these misconceptions: A child's 'disfiguration may be caused by a mother's fright during pregnancy (believed by 1 in 4). Communicable disease can be inherited (believed by about half). Only one-third of those surveyed realized that the lower death rates of today are primarily due to the prevention of infant deaths, rather than to reduce adult deaths.

Closer cooperation on school health policies among the schools, community health officials, parents, and private physicians was urged in a report recently issued by the members of the School Health Committee of the American Academy of Pediatrics. Dr. John L. Reichert, chairman of the committee, said in an interview, reported in the New York Times, that mass physical checkups of school children were apt to create a sense of false security among parents. He said that an adequate physical examination takes longer than is possible with mass methods, and recommended a thorough examination, preferably in a doctor's office, with parents present for proper health protection and education. Dr. Reichert said intelligent health observation by school nurses and teachers should make one examination every 4 years adequate, although the yearly examination is still the ideal ● ● ● The general mortality rate dropped from 17.2 deaths per 1,000 population in 1900 to 9.6 in 1950, the National Office of Vital Statistics, U. S. Public Health Service, reports. Life expectancy at birth in 1900 was estimated at 47.3 years; in 1950 it was 68.4 years ● ● ● A look ahead at New York City's outlook for health services is contained in Now They Live, a publication of the Department of Health, City of New York. The pamphlet outlines some jobs that "should be given priority." Among them are developing more adequate and integrated rehabilitation services for the chronically ill and physically handicapped child; bringing more closely together both curative and preventive services for all children; placing greater emphasis on transforming into practice the present knowledge about the growth of a healthy body and particularly of a healthy personality.

New York is planning this year to launch a $250,000 program to provide

hearing aids for deaf children who cannot afford such devices. The State will cooperate with county governments in financing the program. State officials estimate that 1,500 children in the State are sufficiently hard of hearing to benefit from hearing aids, about half of them in families that cannot afford the equipment ● ● ● Since 1952, after the relaxation of controls on the sales of psittacine birds, the Children's Hospital of Philadelphia has noted a marked increase in the number of patients whose illness was clinically or epidemiologically consistent with psittacosis, the American Journal of Public Health reports.

Welfare

An estimated 285,000 children were receiving child welfare services from State and local public welfare agencies as of December 31, 1952. The Children's Bureau estimates that about 42 percent of these children were from homes broken by death, divorce, separation, or desertion of one or both parents; that an additional 18 percent of the children were born out of wedlock ● ● ●

Because of complex regulations and laws, a large scale study of the procedures and practices involved in international adoptions is needed, the American branch of the International Social Service has stated. One of the points which the agency thinks should be considered in such a study is the extent to which local child welfare and adoption agencies would be willing to cooperate on an international level.

Mental Health

Of 950,000 boys and girls registered in New York City's public schools, 11,500 are classified as retarded and are in special classes, according to Arthur Levitt, a member of the city's Board of Education. He estimated another 15,000 children of school-age in the city have varying degrees of mental retardation and do not attend public school ● ● ● More than 80 percent of American communities fail to provide adequate facilities for emotionally disturbed children who need special care, according to Joseph H. Reid, executive director of the Child Welfare League of America. Speaking before the annual conference of the New Jersey Welfare Council, Mr. Reid said that while 500,000 children with severe emotional disturbances were in need of some kind of treatment facilities, fewer than 1,500 were receiving adequate care in recognized residential treatment centers ● ● ● An education committee of the National Association for Retarded Children has established a clearinghouse to inform local parent groups of what other communities are doing in public school training, courses for parents, recreation programs, legislative action, and research on behalf of the retarded ● ● ● The Gifted Child in the Regular Classroom, a recent publication of Columbia University, reports that while the problems of a gifted child are basically the same as those of others the same age, gifted youngsters may need special attention from adults because of the reactions of others to their special abilities. The publication, by Miss Marian Scheifele, states the gifted child, as well as the retarded one, needs help to accept the inequality of his abilities, to understand his relationship to others, and to accept his responsibility to society.

Juvenile Delinquency

Behavior problems that might lead to antisocial acts in later life are recognizable in a child as early as 3 years of age, according to Dr. Ralph S. Banay, secretary of the Medical Correctional Association. In an address to the third annual Congress of Corrections in New York City, Dr. Banay said the danger period in which youthful delinquency is apt to be at its highest rate is from 13 to 15 years ● ● ● Special court attachés to deal with juveniles have been recommended by a special committee of the New York County Lawyers Association. The committee cited the importance of having a "competent and trained person . . . appointed in every case involving the custody of a child to report to the court those facts which would enable it to determine what would be to the best interests of the child in the case before it." The committee also recommended that judges be trained by the State before being assigned to social courts ● ● ● A report on the Children's Court of New York City has been prepared by Dr. Alfred J. Kahn, Professor of Social Work, Columbia University. Dr. Kahn, who studied the court under auspices of the Citizens Committee on Children of New York City, reported it needed thorough overhauling to reach its original goal. Among his recommendations were a less political method of appointing judges, better training for probation officers, attendants and clerks who deal with children, expansion of counseling, diagnostic and psychiatric services, and provision of more facilities, such as temporary shelter, foster homes and job-placement.

Child Labor

A critical report of conditions under which migrant children live was made last fall to the New York Joint Legislative Council on Migrant Labor by Sol Markoff, associate general secretary of the National Child Labor Committee. "Children are the worst sufferers," Mr. Markoff said. "Despite the earnest efforts of the State Labor Department, hundreds of under-age migrant children are unlawfully employed each year picking crops under a hot sun 10 to 12 hours a day in stooping, creeping, crawling, back-breaking jobs. The housing is frequently indescribable and many migrant families are crowded into filthy, makeshift shelters totally unfit to live in, and without any regard whatsoever for health, privacy or fire hazards."

Half a million more children were employed in 1950 than in 1940, the National Child Labor Committee reports. Largest increase was among children 14 and 15 years old. In 1940, 1 in 23 was working; in 1950, 1 in 11 was earning money. Most children in the labor force are part-time workers, still in school, the report shows.

Research

Nearly $20,000,000 was spent in 1952 for cancer research, and $4,500,000 for poliomyelitis research, according to Richard Weil, Jr., president of the National Association for Mental Health. Mr. Weil said less than $3,000,000 was spent during 1952 on the basic research dealing with the many mental illnesses now prevalent. He predicted that at least $10,000,000 would be needed in 1954 for research and training programs in the field of mental illness ● ● ● Expenditures for medical research have increased at a greater rate than the national income, according to Dr. Kenneth M. Endicott and Dr. Ernest M. Allen of the National Institutes of Health. They report money available for medical research has increased from $18,000,000 just before World War II to $181,000,000.

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Pennsylvania Department of Welfare

Will you come with me for the weekend to Sullivan County? We will find ourselves in a county whose hillsides and meadows are knee deep in the lush green of June and whose mountains with their endlessness widen the heart and stretch the soul.

We have not come to see mountains nor to swim in Lake Eagles Mere, but to help the people in the county decide what they will do for their dependent and neglected children. Some of these children are tucked away in these mountains. Some are uncomfortably visible to the "resorters" at Eagles Mere as even that paradise has its "shanty-town." Still other children are scattered throughout the county.

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It is 7 o'clock, Friday evening. The air carries the sultry aftermath of a severe electrical storm, and the threat of more thunderstorms to come. A small group of perspiring people climb the stairs to the office of the County Board of Assistance where the executive has provided a large table, pads and pencils, and an electric fan.

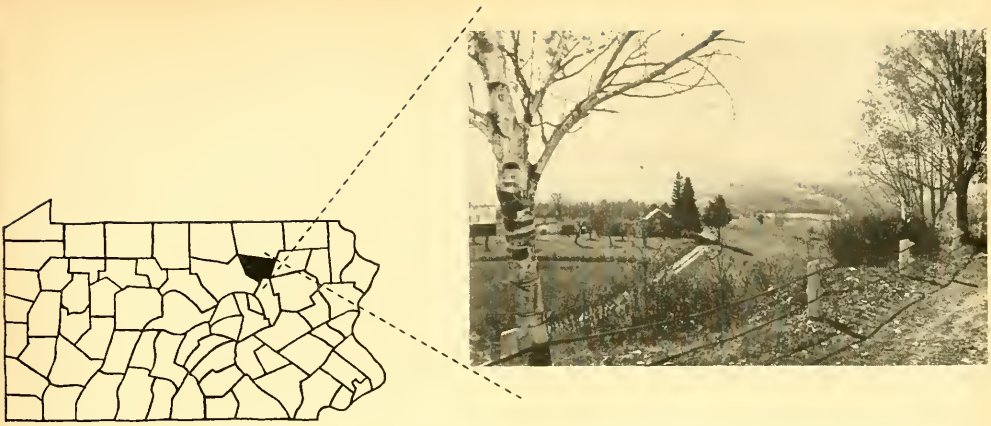
In joining the group around the table, we are introduced to 2 county commissioners, their solicitor, the chairman of the Children's Aid Association who is also county superintendent of schools, 4 child-welfare-minded women from 3 different communities, and my host for the weekend, a newcomer to the county within the last 6 or 7 years and active in civic affairs. The Board of Assistance director is in the group and the third county commissioner, the chairman of the Board, is expected to arrive about 9 o'clock.

Sullivan County has been taking care of its children in the traditional country way—in which "somebody" takes over in an emergency as best he can. The Children's Aid Association, a voluntary, loosely knit, group of men and women, has been working for more than 2 years to improve on these methods, to get something better as well as more dependable for the children who need help. Its members have given many hours of their time and traveled many miles. Tonight they have come once more to plead the cause of children living "down the road" and "back in the hills."

The association has considered various ways in which "something" might be done for these children. Volunteer service has been considered. Also, part-time paid service of a local person whose knowledge of "cases" and sense of social responsibility seemed sufficient qualifications. But it is the program of Rural Child Welfare Services of the State Department of Welfare that they have periodically presented to the commissioners.

The local communities in Sullivan County are too small to provide either the leadership or the funds for voluntary welfare agencies. And each community is so proud and self-sufficient that it finds cooperation with another, except on a county basis, difficult. It is clear that only the county acting as a unit is large enough to handle the problem. There are several ways in which the county might do this. But after considering them all, the Children's Aid Association is convinced that the child welfare services program is the best.

Under this plan the county would have a trained



Sullivan County's beautiful hills and valleys cannot conceal the children needing specialized care.

welfare worker whose salary would be paid from Federal funds and who would be under the field supervision of the State Rural Child Welfare Division. This would mean that she also had the use of psychological services and a centralized adoption service. In addition there would be a local advisory committee that would interpret the program to the public, and help to suggest foster homes.

The county commissioners are uneasy about this plan because they are afraid that if outsiders are involved, the cost to the county will grow larger and larger each year and soon be more than they can meet. But the commissioners have never definitely turned down the proposal. And as long as the possibility remains of getting what they know will meet their needs, the Children's Aid Association members cannot bring themselves to propose any less desirable solution.

And so time has dragged on and frustration has mounted. But tonight the Child Welfare Services Program is again to the fore. The county has recently been shocked by two serious neglect cases which, to the deep concern of the Children's Aid Association, had been disposed of without adequate planning or investigation.

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The atmosphere is electric, not only with storms but with the tension of people who have worked long and hard and who feel that the moment may have come which will decide the future of the county's neglected and dependent children. We see on the faces of some of those present a "now or never" expression and at the same time an eagerness to get on with the meeting, to see if by any chance "Harrisburg" can work miracles. All are ready to study the child welfare services plan which I have brought with me in tentative form.

To their surprise I present 2 plans—1, an extension of the CWS program from an adjoining county for 3 days a week; and the other, a CWS program of their own for 2 days a week. The latter was made possible very recently by the availability of an exceptionally well-qualified person living just over the county line but near enough to be "their worker." When the group learns that this worker is a farmer's wife and has relatives in Sullivan County, plan 1 almost goes out of the window, but the chairman very wisely asks me to review the advantages and disadvantages of both plans.

I emphasize the strengths there would be under plan 1: the tie-in with a well-established agency where there is an experienced director to supervise their worker and the program as a whole, and the availability of at least 3 days a week service. On the other hand, I recognize that plan 1 would be an extension of another county's service rather than their own. In addition, there might be problems in having one set of commissioners providing service to another; I state frankly that such a combination would be new to the Harrisburg office as well as to the county and therefore has many unknowns.

Plan 2 offers the county a program of its own with field supervision from the State office direct to the

county. At the same time it means more responsibility for the county and only 2 days a week service for the children.

The phrase "our own program" goes around the table almost like a Gilbert and Sullivan chorus. One of the women says with conviction, "The people in this county would like to have their ***own program.***" Heads nod in agreement and one of the commissioners says, "This is the program to have—our own and one that does not mix us up with another county." The lone dissenter is the county solicitor who reminds the group that they are taking away one day's service from the children. All of us recognize the truth of this and its implication for children but the "ownness" of the program seems the most important consideration at the moment. One member rather ruefully says, "It would be a small program but it would be a beginning and we just have to get started."

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While this discussion is going on, a summary of the child welfare worker's training and experience is passed around which includes this statement, "She would come to the job with interest and enthusiasm." This brings from one member the spontaneous comment, "Believe me, interest and enthusiasm are what we need! A lot of these people can be helped with just that." All of the group are impressed that the worker is not only a college graduate but has a master's degree in social work.

Comments continue . . . "I hope she knows that it will be a hard job." . . . "She will have to produce results" . . . "Yes; she will have to do some demonstration cases early to show the county people what this service is." Feeling sorry for the worker already, I remind the group that one worker 2-days-a-week cannot work miracles. There are murmured agreements.

By this time the worker is practically *in* the county and the two commissioners are thinking again of money. A "side-bar" conference between one of the commissioners and the county superintendent of schools results in an announcement by the commissioner that the worker's office can be in the office of the county superintendent, thereby absorbing in that budget stenographic service, office supplies, telephone, etc. With a triumphant stroke of the pencil the item for administrative costs from the county funds is crossed off the budget! This would have been the strategic moment for the chairman of the commissioners to arrive. His concern over these costs has been the stumbling block for 2 years. But he does not appear and another thunderstorm, crippling telephone service, prevents any contact with him.

The presiding officer has to leave for another meeting and informal discussion continues into which come the children by name and location, if not in person. The representatives from Eagles Mere talk about the neglected children of "shanty-town"; families where fathers have good jobs but are heavy drinkers and mothers are discouraged by the rejection of themselves and their children by the community. There are children "back in the hills" who do not come to school at all or if they do, with poor clothing and little or no lunch. "Just think what a worker could do for Carrie B. just by showing interest in her." "Look at the children in the L. family—I knew their grandparents and had their parents in school—none of them was able to bring up children decently. How can we expect anything of this generation!" "Preventive work will be the job, helping parents to make better homes."

Then the question comes to me: "How can a worker do this?" I tell the group of my conviction, born out of experience, that ***most parents want to be better parents*** and want to be liked by the people in the community. This is not questioned but rather approved in different ways especially by the women. I remind the group again that the worker is not a miracle-maker, that her interest and encouragement to discouraged parents are first steps in helping. Added to this are her skills in working with people. I point out the limitations in her responsibility, emphasizing that only ***the court*** can remove children from their own homes against the parents' objections.

I describe briefly the difference between a neighbor's approach to a neglect situation and that of the worker who represents not only an authorized agency but also the concern of the community of which the neighbors are a part. This brings comments from several people, emphasizing the importance of saving children from jails and penitentiaries "for their sakes and not just to save money." One member living close to an adjoining county which operates a service has, as a neighbor, one of its agency's foster mothers. She describes with feeling what a good foster home can give children. Climaxing this discussion is a commissioner's comment, "One good citizen is worth a dozen bad ones."

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Time is going on. The group is waiting for the third commissioner to appear, for the chairman to return, for the rain to stop, and above all for the meeting to take some direction. The women are

Laporte, with a population of 175, and said to be the smallest county seat in the U. S. A., is off to a new start with Sullivan County's child-care services.

clearly becoming "determined" to secure a decision from the commissioners, and one of them says emphatically and with some heat "If the commissioners cannot accept plan 2 which is inexpensive and represents a minimum of service then this county is hopeless!"

One commissioner states he is ready to sign plan 2. He looks to the other commissioner for agreement. The latter states that no final decision should be made without the chairman of the board. The group is silent. Will the decision again be delayed?

An empty feeling hovers over the group. It could become bitter. The silence is broken by a member saying, "This is the third time a representative from Harrisburg has met with us at our request. I feel that we have the obligation of courtesy, if nothing else, to make a decision." Again there is silence. The moment seems to have come for "outside leadership."

I offer to stay through the weekend and into Monday in order to see the three commissioners. I say, "The decision may be plan 1 or plan 2, or a refusal of both plans, but the people in the county as represented by those of us around the table are expecting a decision of some kind." The two commissioners react. They decide on a meeting Monday morning, the time to be determined later. The presiding officer who returns just at this crucial point, offers to take a copy of the plan to the chairman of the commissioners to "brief" him for Monday morning. I ask the group if there is enough agreement on plan 2 to discuss it with the child welfare worker while I am near enough to have a conference with her, making clear to her, of course, that no final decision will be made until Monday morning. The two commissioners agree to this and the others express approval.

By this time the group is breaking up and as we go to our cars we are almost oblivious of the pouring rain, so real is our feeling of hope and promise.

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And now we come to Sunday when the chairman of Friday night's meeting stops by to tell us that he has talked with the chairman of the commissioners, who will, he thinks, "go along with plan 2." He has called the Monday morning meeting for 9:30. This stop-by visit takes place during my conference with the prospective child welfare worker—Mrs. B.—who uses the opportunity to express her interest in the plan and her readiness to take the job if and when it is a reality.

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The fateful hour 9:30 a. m. Monday finally comes. We are welcomed by two friendly women in the commissioner's office. One of them is the commissioner's clerk who openly expresses her interest in what is going on and her opinion that "something for children is needed." The chairman of the Child Welfare Association arrives and the commissioners come in with their solicitor.

Plan 1 is not mentioned and the chairman gives his interpretation of plan 2. A few questions are raised and points clarified such as when the worker will come, what days she will be in the county, and whether long distance telephone calls save time and money.

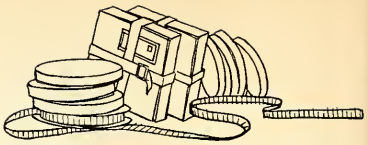
Suddenly, while I am still expecting more questions, the chairman of the commissioners instructs the clerk to write to Mrs. B. for an appointment for their next meeting date. Now it is practically all over and we shake hands all around.

I do not express all the enthusiasm I feel for I realize that this matter-of-fact approach to "high moments" is the pattern of the county and has in it a mixture of a quiet sense of achievement and fear of the unknown.

I leave the group expressing my deep satisfaction in our joint accomplishment and the need for us to stay close together as the program goes along.

As I drive down into the valley and the mountains seem to encompass me, their height seems no greater nor as great as the experience of seeing people use their vision and stretch their souls to encompass the needs of their fellow men.

FILMS ON CHILD LIFE



This department of CHILDREN, which will appear in alternate issues, includes films that have been reviewed by staff members of the Children's Bureau. Listing a title does not constitute endorsement of a film, but indicates that its contents have merit. Charges for rental or purchase, not given because they change, may be obtained from distributors.

BROKEN APPOINTMENT. 22 minutes, sound, black and white, purchase or rent.

A public health nurse learns, in dealing with a broken appointment in a prenatal clinic, how important her attitudes toward her clinic patients are, and how much her own personality influences her relationships with them.

Audience: Public health nurses especially, but also any student nurses.

Produced by: Affiliated Film Producers for Pennsylvania Department of Welfare under the sponsorship of Mental Health Film Board.

Distributed by: International Film Bureau, Suite 308, 57 East Jackson Boulevard, Chicago 4, Ill., for sale; National Association for Mental Health, Film Library, 13 East 37th Street, New York 16, N. Y., for rent.

CEREBRAL PALSY—METHODS OF AMBULATION. 17 minutes, sound, color, rent.

The apparatus used to help children develop ability to walk, and every stage in the preparation of the cerebral palsied child for walking are shown.

Audience: Professional workers; lay groups working to establish programs for children. Not for general showing.

Produced by: National Society for Crippled Children and Adults, Inc., 11 South LaSalle St., Chicago 3, Ill.

Distributed by: Same.

DRUG ADDICTION. 22 minutes, sound, black and white, purchase or rent.

Stressing the "experimenting" idea of teen-agers who get "hooked" because of being "dared" or willingness to "try anything once," the film gives an unmelodramatic picture of how the drug habit is started and what it leads to.

Audience: Teen-agers, parents, professional workers.

Produced by: Encyclopedia Britannica Films, in cooperation with the Juvenile Protective Association and the Wieboldt Foundation, Chicago.

Distributed by: Encyclopaedia Britannica Films, P. O. Box 358, Wilmette, Ill.

FIRST DAYS IN THE LIFE OF A NEW GUINEA BABY. 20 minutes, sound, black and white (Character Formation in Different Culture Series), purchase or rent.

Details, from 3 or 4 minutes past birth, in the care a newborn among the Iatmul suggest the possible influences on personality development of different methods of handling babies. Commentary by Margaret Mead.

Audience: Students of child development; parents' study groups.

Produced by: Gregory Bateson and Margaret Mead.

Distributed by: New York University Film Library, 26 Washington Place, New York 3, N. Y.

FIRST LESSONS. 21 minutes, sound, black and white (Emotions of Everyday Living Series), purchase or rent.

Illustrating the techniques developed by Dr. Ralph Ojemann for the study of human relations, the film shows how an alert and understanding teacher restored a normal and happy balance to a second grade classroom disrupted by a new boy whose emotional difficulties led him to bully other children.

Audience: Parents, teachers, students in various professions.

Produced by: Knickerbocker Productions for Iowa Mental Health Authority, under sponsorship of Mental Health Film Board.

Distributed by: International Film Bureau, Suite 308, 57 East Jackson Boulevard, Chicago 4, Ill., for sale; National Association for Mental Health, Film Library, 13 East 37th Street, New York 16, N. Y., for rent.

GOOD SPEECH FOR GARY. 22 minutes, sound, black and white, purchase.

A second-grade boy who suffers from a speech defect improves his ability to communicate through modern remedial speech teaching. The detailed account of this process underlines the importance to such a handicapped child of having a teacher with a knowledge of a child's nature and needs if she is to help him overcome the effects of such a handicap on his personality.

Audience: Parents, teachers, student teachers, nurses, social workers.

Produced by: The Cinema Department of the University of Southern California.

Distributed by: McGraw-Hill Book Co., Text-Film Department, 330 West 42d Street, New York 36, N. Y.

HOW TO SAY NO. 10 minutes, sound, black and white, or color, purchase.

Five high-school students play out how to keep friends while saying "No" when asked to join in undesirable activities. The presentation moves from situations where it is relatively easy to say "no" to some of the tough issues that face boys and girls.

Audience: High school students; parents, teachers, public health nurses, who might wish to use the ideas as lead-off points in discussions with boys and girls.

Produced by: Coronet Films.

Distributed by: Coronet Films, 65 East South Water Street, Chicago 1, Ill.

KARBA'S FIRST YEARS. 20 minutes, sound, black and white (Character Formation in Different Culture Series), purchase or rent.

Scenes in the life of a Balinese child beginning with his seven-month birthday ceremonial. The child is suckled, taught to walk and dance, tickled, and teased.

Audience: Professional persons concerned with child rearing practices; students of child development.

Produced by: Gregory Bateson and Margaret Mead.

Distributed by: New York University Film Library, 26 Washington Place, New York 3, N. Y.

MENTAL HEALTH. 12 minutes, sound, black and white, purchase or rent.

Situations of significance to high-school and junior-college students are portrayed to illustrate ways of meeting the dangers of bottling up emotions, setting expectations of self too high, failing to make friends through denial of what one has to offer, and worrying about problems rather than facing them.

Audience: Young people, adult lay groups, churches, clubs, P.T.A.

Produced by: Encyclopaedia Britannica Films.

Distributed by: Encyclopaedia Britannica Films, P. O. Box 358, Wilmette, Ill.

MY CHILD IS BLIND. 20 minutes, sound, black and white, purchase or loan.

The parents of a blind child, facing the fact that he will never see, and that he needs help beyond what can be given at home, place him in a nursery school for the blind. The daily routine there shows how much is done to make the children independent, happy in learning, and able to enter into some activities with normal children.

Audience: Lay or professional.

Produced by: Victor Solow of Unity Films for the U. S. Army in cooperation with the Lighthouse Nursery School.

Distributed by: United World Films, Government Films Department, 1445 Park Avenue, New York 29, N. Y., for sale; Association Films, Inc., Broad at Elm, Ridgefield, N. J., for loan under the title I SEE THE WIND.

PRENATAL CARE. 23 minutes, sound, black and white (Education for Childbirth Series), purchase or rent.

The medical care given patients during the prenatal period, with instructions for exercises in preparation for labor and delivery, and the use of breathing exercises during labor.

Audience: Groups of expectant parents when an informed nurse or other professional worker is present to interpret.

Produced by: Medical Films, Inc.

Distributed by: Medical Films, Inc., 116 Natoma Street, San Francisco 5, Calif.

RIGHT OR WRONG. 10 minutes, sound, black and white or color, purchase.

A chain of incidents involving important moral decisions by each boy is set off when a group of teen-agers break windows in a warehouse. Questions are posed whether the decisions of each child involved are right or wrong.

Audience: Adolescents, parent groups, students of teaching or social work.

Produced by: Coronet Films.

Distributed by: Coronet Films, 65 East South Water St., Chicago 1, Ill.

ROOTS OF HAPPINESS. 25 minutes, sound, black and white (Emotions of Everyday Living Series), purchase or rent. (Available in English or Spanish.)

The everyday homelife of a Puerto Rican family and how the feelings of the parents affect the emotional life of their children.

Audience: Groups interested in family life or mental health.

Produced by: Sun Dial Films for Puerto Rico Mental Health Authority, under the sponsorship of Mental Health Film Board.

Distributed by: International Film Bureau, Room 308–316, 57 East Jackson Boulevard, Chicago 4, Ill., for sale; National Association for Mental Health, Film Library, 13 East 37th Street, New York 16, N. Y., for rent.

SHYNESS. 22 minutes, sound, black and white, purchase or rent.

From one classroom, the teacher finds that of three quiet, friendless children, one's aloofness is merely part of his independent personality; one has fears and insecurities that have made him emotionally sick; one is typically shy and without help from understanding and observant persons could become a lonely, frustrated adult.

Audience: Teachers, student teachers, and parent groups.

Produced by: National Film Board of Canada.

Distributed by: McGraw-Hill Book Co., Text-Film Dept., 330 West 42d St., New York 36, N. Y., for sale; National Film Board of Canada, 1270 Avenue of the Americas, New York 20, N. Y., for rent.

THE TOYMAKER. 15 minutes, sound, color, purchase or rent.

Through two of his puppet creations, a toymaker shows how surface differences can lead to conflict and how peace and harmony can develop from mutual understanding.

Audience: Children and adults; leaders of discussions on human relations.

Produced by: Stevens-Rose-Wallace Puppet Films.

Distributed by: Athena Films, 165 West 46th Street, New York 19, N. Y.

V FOR VOLUNTEERS. 20 minutes, sound, black and white, purchase or rent.

When a young woman's interest in volunteer work is aroused, she learns the satisfaction that can be gained by participation in community service.

Audience: Any organization or group trying to awaken interest and increase the number of volunteer workers.

Produced by: National Film Board of Canada.

Distributed by: Association Films, Inc., Broad at Elm, Ridgefield, N. J.

WHEN SHOULD GROWNUPS STOP FIGHTS? (Preschool Incidents, No. 3). 15 minutes, sound, black and white, (Studies of Normal Personality Development), purchase or rent.

Rather serious difficulties arise following four incidents of nursery school play. These conflicts are not resolved, leaving it to the audience to discuss whether or not the teacher should have intervened.

Audience: Students, teachers, parents.

Produced by: Department of Child Study, Vassar College.

Distributed by: New York University Film Library, 26 Washington Place, New York 3, N. Y.

a medical social worker is proving it in Panama, but there are many other places where . . .

VOLUNTEERS CAN HELP

BETTY HUTCHINSON, M. S. W.

Medical Social Work Consultant, Republic of Panama under the Technical Assistance Program, Foreign Operations Administration

MY FIRST IMPRESSION as I walked through the wards of Children's Hospital of Santo Tomas Hospital was that of a sea of little sad faces and big brown eyes that followed every move I made. Wailing children would stop their crying long enough to ask when their mothers were coming to take them home. Older, ambulatory children hung around the doorways or followed at a distance, full of curiosity. The need of others for individual attention and affection was pathetically demonstrated in their reaching out to grab a hand, cling to my skirts, or follow as close as they could, as I walked from ward to ward. Many of the children hung around the halls and the nurse's desk paying little attention to frequent requests to return to their beds. Little groups stood near the elevator doors watching people come and go, fascinated by the operation of the self-running elevator.

My assignment under the Technical Cooperation Program was to develop medical social services at Santo Tomas Hospital, the large General Hospital serving the Republic of Panama. Children's Hospital, a separate building but administratively a part of Santo Tomas Hospital, was selected as the starting point.

A preliminary survey revealed an average of 100 to 150 children of both sexes up to 14 years of age. Most of the children come from Panama City and its suburbs, but many also come from the Interior, especially those needing orthopedic treatment or having serious and unusual illnesses for which no local medical treatment is available. Some children, particularly those receiving orthopedic treatment, remain in the hospital as much as a year. Transportation to many of the villages of the Interior is difficult. In order not to lose the patient and interfere with the medical treatment, these village children are kept in the hospital between operations rather than allowed to go home for intervals. Such children seldom have any visitors or family members to give them individual attention and affection. They are lonely and bored and apt to be a problem to the overburdened nurses who cannot give them the individual attention they need.

A small volunteer program is now operating at Children's Hospital. This program is the result of spontaneous efforts for the recreational and emotional needs of the children on the part of students and social workers who have worked with me in a pioneering venture to develop a social service department.

Obviously, many of these children and their fami-

A former kindergarten teacher has volunteered to help the small patients with their cut-out work.

lies were in need of social casework. But some other needs were even more urgent. Children hospitalized for over a year were missing an opportunity for schooling. There was quarreling among older children. The nurses complained that the children were always underfoot. The few fortunate children who had relatives who could bring them toys to relieve their boredom had a hard time hanging on to them.

Our project got its start in March 1952 when a graduate social worker, employed as a teacher, came to work in the department during her 6-weeks vacation. She had come for some supervised social work experience.

As a teacher and so familiar with the Magisterio Panameno Unido, a professional teacher's association, she suggested approaching this association with a request for cooperation in providing volunteers to teach the school-age children. We drafted a letter to the association, explaining the children's needs and requesting a visit from a representative should the group be interested in this project. In addition, this teacher called on the president of the association to explain the project in further detail.

Weeks went by and we heard nothing. Shortly after our teacher left the department to return to her teaching, two women representatives of the association came to offer their services as volunteer teachers. Both were retired teachers, living on pensions, who had a great interest in children and a real desire to serve them. These teachers were given a brief orientation in the form of introductions to hospital personnel and an explanation of the medical requirements of the children and the ward routines. With the chief nurse, a schedule of classes with the children was worked out for them for the afternoons from 2 to 4, the most convenient time from the standpoint of medical and nursing procedures to bring the children together.

Each teacher now comes two afternoons a week, and both have been extremely faithful in keeping to their schedules. Every Monday, Wednesday, Thursday, and Friday afternoon, school is held on the porch-terrace outside one of the wards. This porch is equipped with small tables and chairs which serve the dual purpose of dining room and schoolroom. The space is open and shady and in an ideal position to catch the cool breezes of the blue Pacific. On these afternoons the wards are half empty and most of the children, able to get out of bed, can be found on the porch surrounding the teacher, working on arithmetic problems, or learning songs and poems. The teachers give individual work to the bed patients.

A bit of the Pacific shows in the background of the terrace where a retired teacher reads a story.

School calls for school supplies, and the teachers themselves could not furnish these from their meager pensions. The president of the Lions Club, an enthusiastic friend of Children's Hospital, responded willingly to my appeal for school supplies. In his characteristically efficient way he appeared a few days later loaded down with notebooks, pencils, chalk, four blackboards and other minimum essentials. The blackboards are now hanging on the walls of the porch-terrace on each floor available to the teachers.

This teaching activity is by no means the equivalent of regular schooling but it helps somewhat to keep up the habit of learning and keeps the children occupied and stimulated. Even the little ones, who do not know what it is all about, tag along and scribble away contentedly. All the children know the days the "maestras" come and inquire about them on the rare occasions when they do not show up. The children's response to the teachers has been touching and the main reward for the volunteer's efforts.

The need for school teaching having been met in part, the next problem was to find volunteers for recreational activities and just plain "mothering." I was extremely fortunate in becoming acquainted with the assistant director of the United Services Organization—Jewish Welfare Board-Armed Services Center—in the Canal Zone. For several years, previous to her present position, she had been a paid director of volunteer services in Beth Israel Hospital in Boston, Mass. She was very gracious in responding

to my request that she visit Children's Hospital and give me some advice as to what activities volunteers could do, how to recruit them, and how to orient them to their duties. The help she gave was invaluable. As a result of her suggestions, the following volunteer information sheet was worked out and mimeographed in Spanish and English to use as a guide and a recruiting device. The English copies were for the benefit of Canal Zone people who might be interested in volunteering at Children's Hospital.

"Dear Volunteer:

"In offering your help you are joining the great number of people who derive genuine satisfaction through some kind of service to mankind. Contributing to the social needs of people calls for devoted service, genuine interest, and responsibility. It requires a sacrifice of time and energy for which you receive little thanks or recognition, no publicity or special benefits other than the satisfaction of contributing to the happiness of others.

"If you are really interested in this kind of service and can give regular service at regular hours, we need you. Below are listed the various activities from which you can choose something that interests you. Some of these activities require that you have training and orientation so that what you do will be well done and of genuine help. The children hospitalized at Children's Hospital need your help and interest.

"Office Work:

Morning hours to do the following activities:
- Type index cards
- Type case histories
- Be in the office to answer the phone

Must speak some Spanish and have a half day of orientation and instruction.

"Recreational and Other Activities With the Children on the Wards:

Afternoon hours 2 to 4, and possibly some late morning hours, for the following activities:

1. Interest the children in games and help in play activities.
2. Provide paper and crayolas and help the children, particularly bed patients, with a drawing period.
3. Provide the children with scissors, magazines, and paste and help them make scrap books.
4. Provide a record player and records for a music period.
5. Read or tell stories.
6. Secure craft materials and teach the children simple crafts.

Numbers 1, 5, and 6, require an adequate command of Spanish. Other activities can be done without knowing Spanish, with much demonstration and imagination. Require one day of training and all work to be done under supervision of the social service department.

"Individual Family Service

Preferably morning hours, but in some cases could be done during the afternoon:

1. Deliver food, clothing, etc., to families.
2. Provide transportation for patients to the hospital or home from the hospital or to other health units.
3. Provide transportation to social workers who have to make home visits in out-of-the-way places in Panama City not reached by ordinary means.
4. Deliver messages to families.

These activities are on a call basis but many could be scheduled to use a volunteer once or twice a week. An orientation period is required of all volunteers who will have contacts with families. All individual family service will be done under the direction of the social worker responsible for the case. Spanish is required except for simple transportation activities.

"Financial Assistance

This does not require that the volunteer maintain any definite hours. It requires making money available to meet the special needs of patients and their families such as food, milk for babies, clothing, transportation, special medications and equipment. Financial assistance to be provided case by case at the request of the social worker or by a regular allowance to the hospital social service fund. The actual food and clothing can be provided in lieu of money when feasible. This activity does not require any orientation unless it becomes involved in actual work in the hospital or in contacts with patients.

"Miscellaneous Activities

1. Helping feed the children at meal time, especially the small bed patients and babies on formula. This activity can be done at break-

fast, lunch, or supper. Requires one day of orientation; does not require Spanish.

2. Guide and messenger service in the out-patient department during clinic hours, 7:30 to 12:30. Requires good knowledge of Spanish, ability to withstand noise and confusion. Will require 2 days of training and orientation.
3. Securing pictures, storybooks, and play equipment for the wards. No orientation needed; no knowledge of Spanish.
4. Taking older children, who have been hospitalized a long time and ambulatory, on day excursions or to your individual homes to spend the day. This is to be done with the consent of the medical staff and the desire of the child and parents. Requires knowledge of Spanish or having someone available who can speak Spanish. One day of orientation and instruction."

These sheets were presented to one woman's organization with a request that it take on volunteer activities as a project. The group was interested, but since it was made up primarily of young married women with small children, the members were fearful of exposing their own children to illness through their contacts with the sick children in the hospital. They turned down the volunteer project, but they offered to help secure supplies and equipment for other volunteers.

No mass recruiting program has been done. Four women have volunteered their time. Each was found individually by use of the volunteer sheet and individual interview. One, a kindergarten teacher, comes every Tuesday afternoon and guides the children in a drawing and paper crafts period. Another schoolteacher comes every Saturday afternoon for drawing activities, to teach songs, and to make the rounds of all the wards talking with the children in an affectionate, motherly way. On her own initiative she is planning a small exhibit of the children's work. A third volunteer brings a record player and plays records for the children on Tuesday mornings. The fourth, a young girl, comes at irregular intervals, as her educational schedule permits, to distribute toys and read stories.

To the children, all these women are "maestras" and when any new person appears in the wards they eagerly inquire if it is a new maestra coming to teach them. An organization of young men, "Los Don Juanes," provides movies for the children every Friday night. This is a mixed blessing: wonderful for the children, but disrupting to the personnel who also want to see the movies.

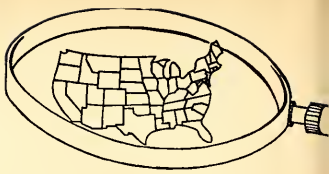
Without the cooperation of the nursing and medical staff this small volunteer program could not have functioned so smoothly. Many more volunteers could be used to good advantage. This program has developed gradually, picking up people as they become interested. As indicated in the registration book in which all the volunteers register their hours of work, so far they have given 120 hours of volunteer service.

The greatest satisfaction to the volunteers has been the response of the children and the appreciation of the nurses who find there are fewer problems when children are kept busy and interested.

"We have reached the age as a Nation when entire towns, cities, and regions have gone to seed economically and physically, and when imaginative, long range physical planning and social engineering are required. Organized health and welfare groups should be a dynamic and integral part of such movements, but they should not and cannot handle them alone. Over 30 years ago Patrick Geddes, the social scientist, coined the phrase 'geotechnics,' which was his term for 'the science of making the earth more habitable.' It is something as broad and comprehensive as that which must concern us in health and welfare planning."

LEONARD W. MAYO,
Community Planning for Health and Welfare,
National Conference of Social Work, 1952.

PROGRAM DEVELOPMENTS



From their vantage points in regional offices over the Nation, the Children's Bureau staff reports periodically developments in health and welfare programs for children. The items which follow come from recent reports of Child Welfare Representatives.

Administration

New legislation in **Wisconsin** creates a department of public welfare in every county to administer all public assistance programs. If requested by the county board of supervisors, this department may administer child welfare services. A children's code commission, created effective July 1, is to make recommendations to the 1955 session of the legislature in regard to various aspects of the child welfare program.

A Division of Child Welfare and Guardianship has been created in the expanded **Minnesota** Department of Public Welfare. This division will include services for retarded children.

Plans have been completed in **Massachusetts** for the transfer of responsibility for the care of approximately 1,100 children now under the supervision of the city of Boston to the Division of Child Guardianship of the State Department of Public Welfare.

In **Illinois** a new Youth Commission has been established with the appointment of a three-member administrative board. Parole services, youth and community services, and the State training school for boys and girls were transferred from the Department of Public Welfare to the Youth Comission January 1.

Missouri's Division of Child Welfare has recently revised its Child Welfare Manual to include a section on Services to Children in Their Own Homes, which includes a definition and discussion of protective services.

Iowa has established a new position to deal with staff development in child welfare. It is expected that this will further improve children's services in public welfare programs, as well as intensify the staff development program.

Licensing and Standard Setting

Licensing of child caring agencies and institutions has received concentrated attention in **Ohio** because of the publication of proposed rules and regulations. After more than 25 years of operation the State Department of Public Welfare moved, for the first time, to issue binding requirements. Ohio will go ahead with the licensing of day-care facilities in accordance with legislation which became effective July 1.

The **Alaska** Territorial Department of Public Welfare has been studying and licensing children's institutions and expects to complete the task by the end of the year. The department will then concentrate on the study and licensing of 34 day-care facilities. Standards of day care are in the process of completion. Plans for a second child-welfare conference are in the preliminary stages.

Adoption

The **Montana** Department of Public Welfare invited representatives of the Catholic Charities, the Lutheran Welfare Service, the Montana Children's Home (which has no institution but operates a foster family care program), and the Florence Crittenton Home to participate in a workshop on adoptions held in Montana, August 31 to September 4, 1953. Discussions pointed up the need for flexibility and high standards as well as for cooperative procedures.

In **Pennsylvania,** with the passage of the Adoption Law, an advisory committee on adoption standards was appointed. The committee has developed minimum standards for agencies or institutions in relation to adoption practices under the new legislation.

Juvenile Delinquency

Rhode Island's juvenile court has cooperated with the University of Rhode Island in developing a course of instruction for police officers, attendance officers, and probation counselors dealing with juveniles. The court is also initiating a community planning program in South Providence in cooperation with religious, educational, social, and other agencies and organizations.

New York City's Youth Board loaned a research technician to Puerto Rico's Child Welfare Bureau to study problems of collecting basic data on the volume and incidence of delinquency. The report recommends the establishment of a central registry for juvenile delinquency. The Governor's Advisory Committee on Juvenile Delinquency is now collecting information on programs of control and prevention.

Three groups are concentrating on the study of juvenile delinquency in the **District of Columbia.** They are the District Commissioners, who have proposed a plan for a District-wide Council on Delinquency with smaller neighborhood or precinct councils to work on the problems; the District's Council on Law Enforcement, created by Congress to study all crime in the District; and a subcommittee of the Senate Judiciary Committee, under the chairmanship of Senator Hendrickson, which is studying Nation-wide juvenile delinquency.

The **Greater Boston** Council for Youth recently approved a 3-year experimental program in an area of high teen-age group concentration which will attempt to (1) identify and reach these groups and individuals who show anti-social and delinquent behavior; (2) strengthen and enlarge basic community services to those with serious social problems; and (3) intensify and coordinate efforts of all community groups

seeking to raise the general standard of living in the area. A tentative budget for this project is estimated at $210,000 for the 3-year period.

The National Probation and Parole Association has been making a Statewide study of needs of delinquent youth in **New Mexico.**

North Dakota's training school received an appropriation to purchase psychiatric service from the recently established State mental health unit in Bismarck.

In **Arkansas** and **Oklahoma** the child welfare divisions of the State Departments of Public Welfare are providing service to one or more of the training schools in their States. Both divisions are offering foster care, when needed, to boys released from training schools and supervision of children returned to their own homes. Public assistance workers in Arkansas are making certain social studies of children admitted to the training schools.

Homemaker Service

Rockville, **Maryland,** has had a demonstration of homemaker service administered by a public health lay council. A study of this program has recommended that this service be placed under a more formally organized agency, and the Board of the Social Service League, a voluntary agency, has agreed to take over the service.

Mississippi is initiating a homemaker service for the care of children in their own homes.

A Division of Chronic Illness Control has been created in the **New Jersey** State Department of Health. In a budget of over $20,000 for the first year, $6,000 are earmarked for a homemaker service and will be used to set up about 10 training centers. These will probably be under the Extension Service of Rutgers University. The New Jersey State Department of Health has made a full-time medical social worker available to the Division with the understanding that the greater part of her time will be spent on homemaker service.

A homemaker service was established on October 1 in St. Petersburg, **Florida,** under the auspices of The Juvenile Welfare Board of Pinelass County. For the present this service is available only for homes where child welfare is involved. With more than fifty applications to choose from, the Board has found eight unusually well qualified women whom they can call on for homemaker service as the need arises. Two of these are social workers who were offered and refused better paying positions in order to do this type of work.

Unmarried Mothers

Funds for new buildings are being solicited by the Florence Crittenton Homes Association in Terre Haute, **Indiana,** and by the Salvation Army in Louisville, **Kentucky.** The Salvation Army in St. Louis, **Missouri,** reports that it is now caring for mothers on a non-segregated basis and that the plan is working satisfactorily.

The **Louisiana** State Department of Public Welfare is revising its standards on maternity home care.

When the **Indiana** Board of Health terminated special medical care for unmarried mothers, the Children's Division of the Department of Public Welfare added this care to its program for unmarried mothers and their babies.

Emotionally Disturbed Children

In **Kansas** plans are progressing for the establishment of a State-operated treatment center for emotionally disturbed children. In making these plans the Director of Institutions has used the advisory services of a committee from the Kansas Council on Children and Youth. A site on the grounds of the Topeka State Hospital has been selected. Final decision on the exact nature of the program has not yet been made.

The **New Hampshire** State Legislature, in its 1953 session, authorized funds for the construction of a residential treatment unit for about 30 children. This new unit will include the present child guidance outpatient clinics. It will be located on the grounds of the State Hospital in Concord, but will be well removed physically from the other hospital buildings.

Handicapped Children

This year, for the first time, the annual conference of the **Illinois** Commission on Handicapped Children included special sessions for caseworkers. At this tenth annual conference, meetings were held for citizens and educators and also for social workers on the subject of The Handicapped Child in the Main Stream.

Indian Children

A child welfare worker has been assigned to Glacier County, **Montana,** to cooperate with the social worker at the Blackfeet Agency at Browning, and child welfare workers have been placed in Bannock and in Bingham Counties, **Idaho,** where they will be available for work with the Indians on the Fort Hall Reservation.

INTERNATIONAL

Widespread interest in the adoption of children from foreign countries continues. New legislation authorizing the bringing in of children for adoption was enacted by Congress in 1953 through two laws authorizing: (1) 500 nonquota visas for children adopted or to be adopted by United States military or civilian personnel employed overseas (Public Law 162), and (2) 4,000 nonquota visas for children to be adopted by United States citizens (Public Law 203).

Two organizations concerned with international adoptions have been particularly active in recent months. One, the International Adoption Association, has been contacting agencies abroad. The other, International Social Service, held a conference in the fall of 1953 to discuss the need for a centralized agency to handle international adoption matters. It was recommended that efforts be made to establish such a service.

INVITATION TO READERS

The number of copies of each issue of CHILDREN—successor to The Child—which can be distributed free of charge is extremely limited. Much as we regret, it is impossible to furnish copies to all persons who had been receiving personal copies of The Child. However, within limitations, we shall make every effort to furnish copies of CHILDREN to:

State departments of health, welfare and education; State crippled children's services located in other departments.
Institutions and specialized courts dealing with delinquent children.
Professional schools accredited to train child health and welfare personnel.
National offices of professional societies and associations.
Foreign and international agencies dealing with children.
University and major public libraries.
Federal agencies with programs related to children.

We request that recipients of copies furnished without charge circulate them among their staffs and that issues be placed in libraries or a central office where they will be available to others.

If your position in any of the above groups entitles you to be placed on the free mailing list, please complete the following application form and send it, as soon as possible, to the Children's Bureau. Your application will receive every consideration.

CHILDREN
Children's Bureau, U. S. Department of Health, Education, and Welfare
Washington 25, D. C.

If possible, please include my name in your free mailing list.

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*Whenever possible, addresses on the free mailing list will bear the position of the recipient, rather than his name.

SOME PUBLICATIONS OF THE CHILDREN'S BUREAU FOR PROFESSIONAL WORKERS

MEDICAL SOCIAL SERVICES FOR CHILDREN. Pub. 343. 1953. 49 pp. 20 cents.

Medical social work evaluates itself in terms of the functions carried by these workers in the maternal and child health and crippled children's services under the Social Security Act. Much of the thinking that went into this pamphlet was generated at a meeting of State and local medical social consultants, and medical social representatives of the professional organization, education, practice in hospitals, and the Public Health Service. Public health administrators, educators, and other professional personnel involved in the care of mothers and children will find this a useful interpretation.

RESIDENTIAL TREATMENT CENTERS FOR EMOTIONALLY DISTURBED CHILDREN, a listing. 1952. 78 pp. 20 cents.

Information is given on 36 centers whose primary function is the diagnosis or treatment of children with emotional and personality problems. Services are as of the spring of 1952. No evaluation of programs is attempted.

CHILDREN LIVING IN THEIR OWN HOMES. Pub. 339. 1953. 52 pp. 20 cents.

The purpose of this publication is to set forth the range of social services that should be available in each community through child welfare programs to help parents in their task of child rearing and thus to safeguard and strengthen family life. Children who may be in need of social services are identified, and the variety of social services required is described.

ALLIES FOR CHILDREN, Child Welfare Reports No. 5. 1953. 22 pp. Individual copies available from the Children's Bureau.

Drawing on plans and budgets of State child welfare services, this report shows how public and voluntary agencies work together in community planning for child welfare.

A SELECTED BIBLIOGRAPHY ON JUVENILE DELINQUENCY. 1953. 41 pp. Individual copies available from the Children's Bureau.

With the need to find ways of combatting juvenile delinquency assuming new urgency, this bibliography has been prepared as a guide to professional workers to recent thinking on matters of cause, prevention, and treatment.

CHILDREN'S BUREAU STATISTICAL SERIES: Main Causes of Infant, Childhood, and Maternal Mortality, 1939–1949. No. 15. 1953. 14 pp.

Personnel in Public Child Welfare Programs. 1953. (Data cover 1952.) 18 pp.

Childhood Mortality from Accidents. 1953. (Data cover 1949.) 6 pp.

Individual copies available from the Children's Bureau.

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A PROFESSIONAL JOURNAL ON SERVICES FOR CHILDREN AND ON CHILD LIFE

U. S. DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
Oveta Culp Hobby, *Secretary*

SOCIAL SECURITY ADMINISTRATION
John W. Tramburg, *Commissioner*

CHILDREN'S BUREAU
Martha M. Eliot, M. D., *Chief*

MARCH · APRIL 1954

children

A PROFESSIONAL JOURNAL ON SERVICES FOR CHILDREN AND ON CHILD LIFE

VOLUME 1
NUMBER 2
MARCH–APRIL 1954

Author, minister, as well as educator, Dr. Buell Gordon Gallagher left his position as Assistant Commissioner for Higher Education, in the United States Office of Education, in September 1952, to assume the presidency of the City College of New York, which ranks third, in enrollment, among the nation's institutions of higher learning. Almost at the start of his career, at the age of 29, he was made president of one of the nation's smallest colleges, Talladega, in Alabama.

A diplomate of the American Board of Neurology and Psychiatry, and trained in psychoanalysis, Dr. Donald A. Bloch started his work with children at the National Training School for Boys, Washington, D. C. When he first joined the National Institutes of Health, his major area of concern was problems of juvenile delinquency. In his present role he is associated with Dr. Fritz Redl, Chief of Child Studies, at the United States Public Health Service's new Clinical Center at Bethesda, Md.

Anne Arundel County's health program developed largely under the direction of the County's former health officer, Dr. William J. French, and its present officer, Dr. J. Howard Beard. Dr. French helped establish child health stations in Paris after World War I, and in 1925 participated in health work in Austria. Before coming to the County in 1951, Dr. Beard had public health assignments in Mississippi and in the Office of the Surgeon General of the Public Health Service. Both physicians are Deputy State Health Officers for Maryland.

Bellefaire, whose Resident Director is Morris F. Mayer, psychiatric social worker, is a regional child-care service for Jewish children in 16 central and midwestern States. It offers diagnosis and treatment for boys and girls 5 to 17 years old who have primary behavior problems, neurotic and prepsychotic disturbances, and who have physical handicaps, brain and neurological damage. The institution has a capacity of 109. Dr. Mayer received his doctorate in philosophy from the University of Frankfort, Germany, and his Masters in psychiatric social work from the New York School of Social Work. Most of his work has been with disturbed children. His present special interest is in the training and development of staff for institutions.

From its start and continuously since, UNICEF has been under the executive direction of Maurice Pate. Its policies are established by a 26-nation Executive Board on which the United States is represented by Dr. Martha M. Eliot, the Chief of the Children's Bureau, in her private capacity. Mr. Pate brought to this great international undertaking experience gained, after World War I, in Belgium under former President Herbert Hoover, and in Poland in the administration of relief.

children®

a professional journal on services for children and on child life
(formerly THE CHILD)

frontispiece

A STRANGER to the ways of a hospital, this little boy waits his turn for attention in the children's wing of the Maranhao State Hospital in Sao Luiz, Brazil, where he is convalescing from tuberculosis. This 50-bed wing has been provided with modern equipment by UNICEF. To prevent TB, UNICEF has helped 39 countries immunize almost 25 million children with BCG vaccine. With UNICEF's aid, production of BCG vaccine is under way in Mexico, Uruguay, and Ecuador, and will serve as a future source of BCG for all of Latin America. (See UNICEF UP TO DATE, pp. 70–76.)

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READERS' EXCHANGE

With this issue, CHILDREN launches a new department which, it is hoped, will grow. Readers are invited to make use of these pages for exchange between themselves of any comments, pro or con, they wish to make on the content of CHILDREN. Individual communications may have to be shortened in order to give others space. Please address communications to Readers' Exchange, CHILDREN, Children's Bureau, United States Department of Health, Education, and Welfare, Washington 25, D. C.

EASTMAN: Supervision Is Essential

Dr. Eastman's article, "Maternity Care Looks to the Future," (CHILDREN, Vol. 1, No. 1, pp. 5–9) is a clear outline of a situation which has concerned all of us interested in maternity care. His arguments are provocative, and demand the serious consideration of every professional worker in this field.

That there will be an increasing problem is evident from the statistical data presented. But Dr. Eastman's figures show that we are already in the early phases of this difficulty. It is a problem for the future arising very acutely in the present.

It is a paradox that a system which has brought about the lowest maternal and fetal mortality on record in this country should lead us into trouble. But a close view of this situation brings to light several interesting facts.

The lowering of the last fractions of a death rate is always a much more difficult task than the early attacks against a much higher rate. It is also true that the methods thus far successful may not necessarily bring best results in the reduction of the last percentage points. Thus, it is not illogical to look to methods that may cut across tradition.

Furthermore, the move toward hospital delivery has developed its own problems. Certain maternity services have become overcrowded and thereby understaffed. The smaller general hospital may not be up to the best standards of obstetrical care. There is a dangerous temptation on the part of both physician and patient to regard any hospital delivery as better than a good home delivery. In many areas also the growth of insurance prepayment has led to a shift from ward service to private care with a great increase in the work of the private physician. Obstetrics places such demands upon the time of the practitioner that at one time he can care properly for a limited number of patients only. Thus, the type of service we have always looked upon as the most desirable—the individual physician caring for the individual patient—in this case may defeat its own purpose. If this applies to the specialist, it does so to a greater degree to the general practitioner who must attend all other patients as well.

It would seem, therefore, that there is a real need for careful evaluation of our *present* problem as well as its extension into the *future*. We must not give up the basic virtues of the methods that have served us well. In this, the emphasis given by Dr. Eastman to the supervision of any type of service by the well-trained doctor cannot be made too strongly. It is essential. But it is equally essential not to tax his abilities beyond endurance.

The type of "obstetrical assistant" that Dr. Eastman describes is beyond doubt the most versatile of all, combining as she does nurse, public health worker, midwife, and assistant. It is worth noting that at least two European countries with enviably low mortality rates have come to regard this kind of trained individual as the best. No one can fit so well into the range of obstetrical care from the isolated service to the teaching center. She can act on her own if she must, but she is the assistant par excellence of the doctor whether he be rural general practitioner or city specialist.

However promising Dr. Eastman's plan may be, I believe, its success must depend upon a thorough understanding by the doctor, the "obstetrical assistant," and the patient herself of the role each plays. The doctor can never relinquish his responsibility of direction and control and must never lower the dignity of his obstetrical assistant to mere routine technical levels. She is, in fact, an "obstetrical associate." This nurse must herself feel the utmost loyalty to the doctor and be guided by the most critical conscience in the judgment she exercises. And the mother-patient, her husband, and her family must accept willingly this service not as a substitute but as a fundamental advance in obstetrical care.

Dr. Eastman, and all those who have helped in the development of this experiment, are to be congratulated. Perhaps most to be envied are those nurses who are pioneers in this bright new field.

Samuel B. Kirkwood, M. D.
Commissioner of Health
Commonwealth of Massachusetts

EASTMAN: Will Parents Accept?

Dr. Nicholas J. Eastman has given us some very thought-provoking facts and figures relative to the problem of maternity care in the next decade. Just as every overworked obstetrician in 1947 warned his Commissioner of Public Schools to expect a huge increase in first grade pupils about 1953—and this did happen—so is Dr. Eastman warning us that between 1967 and 1970 these first-graders of 1953 will be reaching marriageable age. And so he forecasts "more babies and more maternity work" 10 to 15 years hence.

As I see it, the problem that Dr. Eastman raises is—where are we going to get the personnel to care for these mothers? I would also like to add, not only the right kind of personnel to give the safe maternity care that we have watched develop with gratification and

pride over the years, but also the emotionally satisfying care for parents and babies which most of us feel is so important today.

In World War II, with many young doctors called to military service, obstetrics faced a shortage of personnel. In spite of this, maternity care was accomplished with a reduction in maternal and infant deaths. How was this done? To the credit of the obstetricians and nurses in civilian practice we must not forget that the most important factor was their ceaseless work almost to the point of collapse. But let us also remember that at this time was introduced the "assembly line" method of maternity care: hurried prenatal examinations by doctors; mothers being left alone throughout most of their labor; few and unprepared nursing personnel attempting to give care to too many mothers. Unfortunately, today, in many hospitals, mass production is still apparent, even though many physicians and nurses have returned to civilian duty.

I can visualize the kinds of questions and the turmoil in the thinking of professional and community groups that Dr. Eastman's proposal will raise. Physicians will comment that nurses are invading their territory. Medical educators will ponder on the problem of sufficient "clinical material" for both medical students and the "Obstetric Assistants." Hospital administrators and the nurses themselves will want to know who is going to finance this venture. Mothers and fathers who have always put such confidence in their obstretrician—will they accept or look askance at this "Obstetric Assistant"?

Before we answer these questions I think we should look squarely at "the future of obstetric care." What kind of care do we want for mothers? Shall it be the assembly line method? Or shall it be the sympathetic, supportive and highly personalized attention which a few, but too few, nurses are now giving, in some medical centers, and which the "Obstetric Assistants" are giving at Johns Hopkins Hospital? Do we want mothers to be prepared for child-birth so that it will not only be safe, but one of the most thrilling and satisfying experiences of their life? Do we want mothers and fathers to take home from the hospital a baby whom they know and have already learned to love rather than a bundle of blankets in which is an almost unfamiliar baby whom they scarcely know how to handle?

Will there be justification for the doctor's concern that these nurses will be invading their territory? Surely they have every right to be concerned when great emphasis has been placed on early and constant medical care during pregnancy and hospital delivery by a physician. Dr. Eastman predicts that with an increase in birth rates in the late 1960's and insufficient medical personnel, some thought must be given to provide more personnel. If the medical profession cannot meet this great need should they not turn to an allied profession?

I am certain many physicians will not want to accept any such idea, foreign as it is to their concepts and philosophy. However, I feel that if groups of community leaders, doctors and nurses sit down, face reality and plan for the future, some physicians will feel that these maternity nurses are not invading their territory, but working with them to care for these future mothers-to-be.

Some may ask where we will get nurse recruits for such a venture when already we are facing a nurse shortage. Maybe it behooves hospital nursing administrators and nursing educators to define and clarify the duties of a maternity nurse. If the maternity nurse could and would perform only those truly professional tasks, as many of us think she should, and leave the nonprofessional duties to those less qualified, I feel certain we would have no problem in getting highly qualified nurses for maternity service and for "Obstetric Assistants."

Will there be sufficient "maternity patients" for the training of both medical students and "Obstetric Assistants"? If the birth rate increases as Dr. Eastman predicts and if at present "a fourth of the babies that are born in a certain large municipal hospital" are without benefit of medical attendance, it would seem to me that we need not fear this.

Who will finance this educational program? No doubt it will be costly. But is anything too costly that enables us to give better care to mothers? Are not our parents willing to pay, to the best of their ability, for good medical care?

What will be the repercussions from expectant parents? For years mothers in European countries have been delivered by trained nurse midwives. Many of us, I am sure, have talked to American women who were delivered of a baby by one of these nurses, under the direction of a physician, and felt confidence in her skills. Yes, it would take education to change the concepts and thinking of parents and the general public, and they, as well as the physicians and nurses, should be on the "ground floor" planning.

As I look to the future, with hope and confidence, I can see this "Obstetric Assistant" as a part of this great maternity team. She will give supportive care and safe delivery to the normal gravidae; she will relieve the obstetrician of the pressure of work so he may have more time for the mothers with complications and for research; she may work with a group of general practitioners in a rural area, caring for mothers so that the doctors may have more time for medical and surgical patients who may be critically ill. In schools of nursing she will help upgrade basic and post-graduate nursing education so that maternity nurses will be able to give the kind of service they would like to give and parents will receive the comprehensive care they are asking for and so humanly deserve.

Elizabeth Peck
Associate Professor, Maternity Nursing
School of Nursing
Syracuse University

EASTMAN: Another Type of Obstetric Service

Here at the Medical College of Georgia there has been in operation for several years a project as follows. A semi-basement room, approximately 45 by 60 feet, is divided into a delivery room, a labor room with 4 beds, sleeping quarters for resident students with 4 to 5 beds and accompanying bathroom facilities. This serves as a maternity shelter for Negro multiparas who were formerly delivered by the students in the patient's home.

At the same time it may serve as a model for a type of obstetric labor service adaptable to office delivery in rural practice, in contradistinction to time-consuming and otherwise unsatisfactory care of labor in the patient's home,

or to more expensive and frequently unavailable hospitalization.

The success of the method is attested to by the increased use of office delivery service especially in the southeastern portion of the United States.

Students, late in the junior or early in the senior year, are on duty, each continuously for 3 weeks. They reside in the component student quarters. They are staggered as to time of service, so that never is the service in the hands of completely inexperienced personnel. An assistant resident occupies an adjacent room and is present for advice and instruction at each delivery. Each student delivers or assists at the birth of approximately 30 infants.

The patients are transported to the shelter by relatives or friends at the onset of labor. They are advised of the procedure while attending a prenatal clinic associated with the University Hospital next door. If any complications arise, the patient is admitted to the hospital. For nurse attendance, they are requested to bring a capable female relative or friend, who is then instructed in the subsequent care of the mother and baby. A few hours after delivery the mother and child are taken home by ambulance.

This then becomes a training center for the future rural physician who, in many instances, has later developed a maternity shelter at his office where any patient in his territory who desires may have delivery service following prenatal care given in his office by him with help of an office secretary or nurse or at a nearby clinic run by the health department at small cost. With these conveniences, preferably with nurse assistance, he is able to alleviate some of the labor pain by appropriate medication, auscultate the fetal heart tones at intervals of time, and give oxygen or fluids to the mother if indicated. At delivery he is equipped to tracheal intubate the infant if necessary, to pack the excessive bleeding uterus on occasion, and to perform an adequate perineal repair which is essential to the future wellbeing of the mother. Furthermore, and of immense importance to him, he is able to conduct his office practice with some degree of regularity in that the laboring patient is close at hand.

From my 7 years experience as an isolated rural practitioner I am convinced that prenatal care in obstetric service is the most potent factor in cementing a physician to the hearts of his patronage and of obtaining the confidence of the community. A new baby successfully introduced into a household becomes a bond of friendship of the most gratifying sort.

During labor such a variety of abnormalities may suddenly develop that successful outcome may tax the knowledge, judgment, and experience of the highest obstetrical authorities. It is true that such aberrations of labor happen infrequently and that is why many thousands of cases are conducted by granny midwives, especially in the rural sections of the South, with surprisingly low mortality to both mother and child although it is reasonable to expect it to be relatively much higher than in other sections of the country.

Nearly half of the births in the United States occur in rural towns or country. It seems to me that the Nation's thinking should be directed toward improving the education, facilities, and economic lot of the rural physician in the following manner since he is the only one in the community capable of being able to cope with all complications. This includes continuation of the rural prenatal clinics conducted by the health department with the local physician's (or physicians') attendance on an hour or per diem paid basis. At the time of delivery he is in charge, in the main, at a local maternity shelter, preferably owned and operated by him, with the aid of a public health nurse or of a local trained or practical nurse or even a midwife whose actions he controls and whose future training he assumes in part at least. Most complications can be sucessfully handled in such a place. Those that cannot he may transport to a hospital of his choice. He is able to get the patient in the best possible condition for the transportation and supervises the care during transportation. For indigent patients he should be paid from public funds enough to insure his continued interest in the project but not enough to unduly deplete the funds.

In many communities hard pressed for a resident physician the above plan would: (1) add materially to his otherwise inadequate income; (2) increase his prestige and give him a closer tie to the inhabitants; (3) add to his training and experience inasmuch as he learns something from each patient and more from those with complications; (4) enable some communities which have no physician to obtain one, essentially by subsidizing indigent maternal care, a worthy project in itself but one which should be locally controlled. It should be financed locally enough to make people conscious of the cost.

This is in no wise an adverse criticism of Dr. Eastman's proposal which seems to be admirable. It is merely another slant on the possibility of improving, at low cost, obstetric practice especially in rural communities where such is greatly needed, and in areas of the South where hospital care is geographically and economically often lacking.

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REDL: Research Aids Courts

For those of us who are interested in children and their problems in adjusting to wholesome and happy family and community living, it is gratifying to know that continuing studies, such as that described by Dr. Fritz Redl in "Child Study in a New Setting" (CHILDREN, Vol. 1, No. 1, pp. 15–20), are being made which will enable us to better understand the particular problems of individual children and to develop more appropriate and effective treatment and training methods for all children.

While the proportion of seriously disturbed youngsters passing through the court may not be sizeable, nevertheless, the number seems to be growing, particularly among younger children, and it becomes increasingly important that we discover means of earlier detection of emotional problems and that we develop more accurate criteria for determining appropriate treatment processes.

In presenting articles such as this by persons of such experience and professional standing as Dr. Redl, CHILDREN renders an important service in stimulating hope and assurance that further research will make possible a wider knowledge and understanding of the problems with which we are dealing.

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THE FALSE DICHOTOMY OF PROFESSIONAL *VERSUS* GENERAL EDUCATION

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THE PROBLEMS OF SOCIAL WORK EDUCATION are not fundamentally different from the problems which beset any form of professional education. The manner of working out the answers to problems, and the specific character of the results obtained, will be different in social work from engineering or medicine or astronomy; but there is a basic core of similarity in the complex of problems faced by all professional education today. And the hard irreducible core of difficulty common to all professional education is—according to this first of my contentions—just this: professional competence demands certain specializations, while personal and cultural values demand much wider and more generalized education.

There has just come to my desk the annual report of a distinguished colleague in the fraternity of educational administrators. His report takes up at some length the argument that these United States can no longer afford to maintain two and a quarter millions of post-high-school youth, large sections of whom are pursuing other than vocational and professional studies. He argues that circumstances are forcing the private colleges to price themselves out of the market, while the public colleges will find themselves crowded off the shelf of tax support by their newly welcomed and fast-growing companions, "unemployment and old age benefits, health insurance, and other social objectives that will be even more sought after than higher education." His answer is to "give more education in less time" by scrapping the notion of the 4-year liberal arts college altogether. Instead, a transformed and intensified junior and senior high school will provide all the terminal education any American youth deserves, except for those who go on to pursue professional courses of study. As an afterthought, he would permit those who wish to study beyond the high school "outside the traditional professions" to attend low-cost 2-year terminal programs, nonspecialized in curriculum and nonresidential in character. As for the professional education which is to make up the great bulk of post-high-school studies, my colleague argues that the burgeoning of man's knowledge to unmanageable proportions now places such demands on the undergraduate's time that he cannot hope to accumulate even the requisite specialized information and skills while he is matriculated.

The unstated conclusion is that there will be increasingly less room in the professional curricula for the humanities and for cultural studies. The liberal arts, according to this line of argument, must be largely eliminated if the demands of technical performance are to be served. And to clinch his argument, my friend concludes that the only way we can meet the demands of professional competence, even with all these other expedients, is to add to the period of professional instruction a subsequent period of interneship in all professions.

Personally, I am grateful to the president of the Cooper Union for stating so forcefully and logically the conclusions to which his general thesis leads. He states the case—and states it well— for the substantial elimination of liberal and general education in favor of professional competence.

At the opposite end of the scale in this current discussion are scores of other college administrators who are dusting off the old arguments in favor of liberal education. One suspects that they do so primarily because all their colleges have to offer is a

From an address before the Council on Social Work Education, Washington, D. C., January 29, 1954.

liberal arts course (with some professional or vocational courses added here and there); and it is understandable that a man should speak up in defence of his wares if he wishes to sell them. Not all of them are scared rabbits, to be sure; many are men of conviction who, like the friend earlier alluded to, have the courage of their convictions. And I will be among the last to suggest that the values of a liberal education should be sacrificed to the demands of professional curricula.

Nevertheless, I think it might be useful to point out in passing that what we now refer to as the liberal arts course of study is historically derived from a professional prototype. What were the early colleges and universities? Were they not precisely the professional schools of the then few learned professions? And aside from the men who pursued classical learning in preparation for ordination, who else attended? Few others except the idle sons of the gentry. From time to time there must have wandered into the collegiate halls an occasional seeker after truth for truth's sake—or for the sake of the search. But the point is that so-called liberal education is, in terms of its origins, nothing more nor less than education for special professional competence. I suppose the argument has been that since it was good enough for future divines, it ought to be good enough for future humans as well. And thus has professional education for the ministry become the base for the liberal arts.

Those who would defend liberal education against professional education are, I submit, standing on shaky historical ground. The degree to which their arguments appear to carry conviction today is merely a measure of two things: (1) the extent to which many things other than the original professional core of divinity studies have been added and interspersed or even have supplanted classical studies, while the liberal arts label has been retained, and (2) the power of the pressures of conformity which were so eloquently stated by Plato in his Republic (S424): "This is the point to which, above all, the attention of our rulers should be directed—that music and gymnastic [the whole of the curriculum of Plato's day] be preserved in their original form, and no innovation be made * * * And when any one says that mankind most regard

'The newest song which the singers have,'

they will be afraid that he may be praising, not new songs, but a new kind of song; and this ought not to be praised, or conceived to be the meaning of the poet; for any musical innovation is full of danger to the whole State, and ought to be prohibited."

If one must sing a new song, let him be clear that it is not a new *kind* of song—call it liberal arts even though it is neither artistic nor liberating. And so the wheel comes full circle, and one can acquire the degree of Doctor of Philosophy by writing a thesis comparing the relative values of three different methods of washing dishes.

What has actually happened is that the necessity to defend indefensible specializations has led educators to call black white and insist that these specializations are, after all, merely specialized parts of the general whole. Each fragment of curriculum will glow with the sacred aura of the liberal arts if only its proper surface is polished and exposed to reflect the light. No one fragment of the mosaics in St. Sophia's at Istanbul is, of itself, a great work of art; but when the whole is viewed, each special bit becomes part of a magnificent picture. So runs the argument. And under this specious brand of thinking, liberal arts education has been made to sire the most absurd offspring of vocational and professional specialization. I submit that common honesty and decency should lead educators to tell the truth about what they are doing, to abandon the fiction which now so largely makes up the reading matter in college catalogs, and to state frankly that much of what they are offering under the aegis of a liberal education is what liberal education was originally—professional education.

But the argument does not end there. Indeed, it has only begun when we reach that point. For then we are right where President Burdell of Cooper Union stands, and we must meet him on his ground. This I propose to do.

At bottom, the problem of professional versus liberal education cannot be resolved by eliminating one or the other, or by separating one from the other. My contention is that the only satisfactory solution of the difficulty lies in achieving the proper seminal relationship between the two. I hold that it is false to establish a dichotomy between professional and general education; and I hold that it is disastrous to build this false dichotomy into an antinomy. To turn out from our schools and colleges technicians who are ignorant of the arts and innocent of the humane studies is to commit cultural hara-kiri—and it is little excuse to say that at any rate the sword

is technically perfect. It is probably true that the technologists of the future will largely determine the fate of mankind; and I shudder in horrendous fear to contemplate a future which is in the hands of technological giants whose power is not subject to moral control and whose acquaintance with art and literature does not go beyond comics and whodunits.

Moreover, if these considerations apply in such fields as the natural sciences, they apply with all the more weight in the social sciences. Will any person admit that a man is adequately trained either to sit on the bench or to appear before it if his knowledge of the law, however complete and professionally adequate, is uncorrected by a single humane impulse, unenlightened by a glimmer of the social forces which play upon the individuals who pass in review before the processes of law? What psychiatrist or medical man is worthy of trust if he is unscientific enough to disregard the facts of human existence—including the value judgments of his patients? Or what social worker is ready for professional performance if his undergraduate and graduate training include all available materials of the profession and nothing else?

Fortunately, we do not have to choose between competent technicians and incompetent sentimentalists as we establish our notions of the desirable professional practitioner in any field. Having discarded that antinomy, we are then in a position to quit talking about "General *versus* Special Education," and to get on with the job of exposing prospective professional people to the educational experiences which will make them professionally competent in every sense of the word. And no person is competent to perform in his profession unless he is fully aware of the meaning of his daily duties in the larger social whole. He is not competent in his profession unless he brings to it some degree of enrichment in his own personality, over and above the technical perfection he possesses. If these things were not true, then we should quickly abandon the whole farce of education and put our future into the hands of the electric brain with an army of robots while mere men with glands and gray matter put themselves out to pasture with the cows.

In short, my contention is that it is wrong, morally wrong, to separate technical and general education from each other and then to set them in opposition to each other. Instead, we must devise that kind of preparation for each and every profession, including social work, in which the learning student acquires the skills and knowledge of his peculiar professional pursuit while also acquiring with these in a single integrated pattern of meaning those things which make him an interesting personality, a responsible citizen, a good homemaker, and a constructive member of the world community. Some of us, and I am one, would also welcome fuller opportunity for the cultivation of the dimensions of the religious life.

Now, this general difficulty of all professional education has its special point of emphasis in education for social work. I have been saying that the only kind of professional education worth offering is an education which turns out not mere technicians but men and women. My second argument is that, far from being easier, this goal is much more difficult to attain in social work education than in many other fields. This difficulty derives from the peculiar dilemma of the profession.

By definition, the profession of social work is concerned with the good life. But by compulsion of circumstance, practitioners of that profession must devote their energies largely to correcting the uneven results of the struggle for the goods of life. There is a sense in which the crux of the social work problem lies in the effort to prevent the struggle for the goods of life from eclipsing the sharing of the good life.

For example, one of the values of the good life as we know it in a democracy is the thing we call equality of opportunity. But as Judge Jonah Goldstein reminded me the other night, it does little good to put a diamond necklace in the window at Tiffany's with a sign reading, "Price $25,000; for sale equally to rich and poor." If equality of opportunity is to be effective, that opportunity must be real—not theoretical. And since the accepted standards of value in this democracy firmly support the ideal of equal opportunity, our constant struggle is to maintain the integrity of that ideal in the face of partial realization in practice. Much progress has been made in lowering the barriers of race, creed, economic class, and national origin. Much progress remains to be made.

Social workers are aware of these things, and good educational preparation for the profession develops this awareness into understanding. Unless this understanding of the contradictory compulsions of life's pressures is adequately developed and fully equipped with sound judgment and appropriate

attitudes and techniques, the social worker is not a fully competent practitioner. Devoting much of his time to the task of getting the goods of life for his clients, he may lose sight of the good life which is the goal; or, keeping his attention on the good life, he may forget that a hungry person finds it difficult to sing hymns. In his effort to be fully professional and objective, he may become calloused and indifferent; or, yielding to the natural impulses of concern for persons in trouble, he loses his objectivity and with it his real opportunity to be of service.

This dilemma is not limited to social workers, but it is of special and peculiar importance to this profession. More than any other single professional group, social workers must help their clients to face successfully the continuing struggle to keep the hungers of body and mind from feeding on the corpse of the spirit.

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delinquency seen as an interpersonal integration has certain implications for treatment

SOME CONCEPTS IN THE TREATMENT OF DELINQUENCY

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IN ORDER TO DEVELOP a rational conception of treatment of any condition, we need to have explicit hypotheses as to *what* we are trying to modify, and *how* we are to go about it. Then, if we are wrong, we at least have some chance of finding out what we are wrong about, and if we are fortunate enough to be successful we have some chance of duplicating the experience. It is in this spirit that the following conceptions about the treatment of delinquency are presented. They are intended as speculative and, hopefully, as provocative, with the main attention directed to areas which seem to be difficult or obscure.

Modern psychiatry recognizes that a diagnosis is not a fact, but simply a more or less useful construct erected about that biological, psychological, and sociological continuum called a human being.

When we consider the wide range of behavior called delinquent, and the diverse personalities of those who carry on the behavior, we are hard put to discover a common thread which links them. Indeed, one may well raise the question as to whether such a thread exists. It is my assumption that one is more likely to find this thread if one considers delinquency as an interpersonal integration. Essentially, this means that we take the two-group as our unit of observation and therefore look on delinquency as an interaction *between* people, rather than as a phenomenon occurring principally *in* a person.

An example frequently given of an integration is a dog fight. In studying such a fight, one might quite reasonably examine separately the neurological and psychological aspects of the behavior of each individual dog. A very lifelike and useful sense about what is "going on" comes, however, from a consideration of the way in which the *two* dogs are interacting with each other. The totality of the interaction we would call the integration.

Making a diagnosis in this conceptual system involves a shift of our attention from the individual to his characteristic mode of integrating interpersonal situations. Since the *meaning* of the integration is derived from the interaction between the two

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participants, it follows that we become considerably more interested in the role of the partner in the integration. Typically, for the delinquent the partner may be a parent, teacher, judge, psychiatrist, social worker, or a phantasy figure. Returning to our two dogs for a moment, we would assess the behavior of one of them in terms of the behavior of the other. Thus, the notions we might have as to what is "going on" for a particular dog would depend on the behavior of the partner. We would make a considerably different evaluation if the dog partner were a snarling cur than we would if it were a bitch in heat. Regarding delinquency as a particular way of integrating an interpersonal situation has certain implications which are relevant to treatment.

The continued use of an integration depends on several factors. It must serve the function of mastering anxiety and, in addition, it must help to secure minimal satisfaction of needs. From a genetic point of view, we assume that the early childhood experience of an individual provides a setting which facilitates the choice of particular ways of integrating interpersonal situations. Of chief importance in this choice are the characteristic ways used by the *parents* to avoid anxiety and achieve gratification. As the child grows up in the context of these parental attitudes, he develops certain expectations of the world and along with this a battery of techniques for molding interpersonal situations in the light of these expectations. The expectations loosely correspond to what is usually called superego. That is, they represent the aggregate of internalized, parental qualities. The battery of techniques for molding interpersonal situations may be thought of as integrative tendencies, which have as their goal the avoidance of anxiety and the achievement of gratification. It is the chief function of these integrative tendencies to mold the interpersonal situation so as to avoid any responses of the partner which are apprehended as anxiety producing.

A 17-year-old, of an upper middle-class family, was on probation for a serious crime—kidnapping and sexually molesting a young girl in the company of some other young boys. The crime seemed to grow out of an attempt to cope with mounting pressure toward heterosexual intimacy. He was a handsome, sullen, terribly isolated youngster whose goal in life appeared to be to demonstrate that he did not "need anyone." The only events which relieved his gloomy impassivity were those occasions when he could demonstrate how evil someone else was. On evenings when he had nothing to do, the usual lonely state of affairs for him, he would go out driving in the family car. On one occasion he located a cruising police car and began to follow it. When the police noticed they were being followed, they circled behind him after some considerable difficulty, and pulled him over to the curb. As they questioned him, he rolled down the window and insolently blew cigarette smoke at them. He triumphantly described this story to me as an example of the way in which the police picked on him. The father of this boy is an aggressive, rejecting, and somewhat delinquent person. The mother is a weak, inadequate woman who controls her dangerous, forbidden impulses by excessive religiosity.

Substantial data in this and other cases indicate that the smooth and unruffled façade of the most severe psychopathic delinquent masks considerable and potentially overwhelming anxiety. While ordinarily appearing to be apathetic, my patient was restless and apprehensive in situations which brought him into intimate and close relationships with others, or where there was a hint of such needs. At those times he would cast about for, and almost inevitably find, some way of converting the situation into a crime and punishment interaction. His anxiety disappeared when this was successful. Those things which might make anyone else uneasy functioned to make him more comfortable. Much psychopathic behavior becomes clearer to us when we recognize that it is anxiety-driven.

Two other features of the case are worth examining. The first has to do with the specific sources of anxiety. The original crime, that is, the kidnapping and sexual molestation, seemed to grow out of a profound sense of inadequacy in heterosexuality. This rested on a base of intense difficulty in dealing with his peers or with parental figures in any kind of intimate situation.

A second feature which is valuable in understanding such a case is to consider that aspect of the interaction which is constructive and gratifying. We are quite familiar with the damaging aspects of the delinquent integration, but often we do not recognize that it is genuinely an integration, that is, a way of carrying on a task with another person—the giving and receiving of the goods of life. The delinquent is as entitled as the rest of us to have it said about him, "He is operating at the highest level he is capable of at the moment." Thus, in my patient's experience with the police, we notice the provocativeness but may overlook the need to have some kind of satisfactory relationship with an authoritative

male figure, which also plays a part. For this boy, furtive sexual manipulation of a resistive girl was the best he could manage in the way of heterosexual intimacy at the moment.

In terms of the defensive aspects of this integration, we might say that the goals are to avoid those situations which made for anxiety in early childhood, chiefly situations of need for care, closeness, and intimacy. It is characteristic of puberty and adolescence that biological and social pressures act to foster greater intimacy. And clinically, we find that the two groups which burst forth in symptomatic flower at that time comprise those who have the greatest trouble with intimacy—the schizophrenics and the delinquents. The delinquent handles his anxiety, as do all of us, chiefly by evoking in other people responses similar to those of the parental figures—specifically, in this case, rejection and punishment. Failing to evoke rejection, for example, where there is an atmosphere of persistent good will and lack of response to the delinquent's provocativeness, he can and does engage in other defenses, such as aggression, flight, perceptual distortions, and misinterpretations. Another defense is to assume the punishing role toward himself. Examples of this are the waves of tattooing and self-mutilation one sees in training schools. (It is interesting to note the similarity in character structure between the delinquent and the accident-prone individual.)

The common thread of the delinquent integration may then be that the partner with whom the delinquent behavior is carried out responds to it conventionally by punishment and rejection. The teacher who upbraids a truant pupil, the policeman who beats up a youngster, the community that houses a runaway in a jail with adult criminals, the mother who sends her disturbing youngster away to military school, the community that segregates its delinquents, and the training school superintendent who does not notice sadism and red tape, all are dramatically playing the classic role of the "partner" in response to the delinquent. The delinquent actively participates in evoking this kind of response from those around him. It is my thought that he does this in part because it recapitulates the early life experience of rejection, deprivation, and separation characteristic of the lives of so many severe delinquents, and that the process is carried on beyond early childhood principally as a defense, to avoid experiencing dangerous dependent needs.

We might consider the delinquent's view of the world in terms of this defensive system. It seems to me that the rejecting, ungratifying parent of the delinquent childhood has, in a sense, become internalized into a harsh, unremittingly punitive figure. Carrying this particular notion about the real nature of other people, the delinquent is constantly on the look-out to defend himself against dangerous intimacy and to demonstrate that there is no possibility of another kind of relationship. Putting it simply, he is out to prove that everyone is either a crook or a sucker or a rejecting figure.

As in other neurotic patterns, the tragedy of delinquency is that it is successful, and corrective life experience is avoided. Having once been "the children that nobody wants," the delinquents have extremely effective systems for continuing in that role. They are particularly perceptive of unworthy motives or, putting it another way, of the forbidden impulses which other people have. All kinds of relationships are turned into crime and punishment interactions. Along these lines, I would refer to the work of Adelaide Johnson and Stanislaus Szurek.[1] They have, using a different theoretical frame of reference, pointed out the way in which delinquent acting out develops in relation to the forbidden impulses of the mother; the child acting, as it were, both as her agent and whipping boy.

The defenses of last resort for the delinquent are open, aggressive hostility and, finally, flight. For some who are particularly vulnerable or who are faced with particularly dangerous situations, the last resort may be close to the first resort. This is of considerable importance in any treatment program which must be designed staffwise and equipmentwise to forestall these episodes as far as possible and to withstand them when they occur.

In the main, this paper will deal with conceptions relating to the treatment of youngsters who use this particular technique of dealing with people sufficiently extensively to be called severe delinquents. It is worth noticing that one can use an integration to a greater or lesser degree. To analogize with other psychiatric entities, all of us engage in some denial and repression, but only those who go in for this sort of thing extensively merit the term hysteric. Many of us respond to anxiety, on occasion, with a burst of activity and some euphoria, which does not make us all hypomaniacs; nor need occasional withdrawal and dissociation label us as schizophrenic.

In discussing treatment I will limit myself to certain aspects which appear to be particularly relevent

to this group, with the not always warranted assumption that a substratum of recognized services to children is available.

There are several points of attack for a rational treatment program. First of all, as to prevention. If it is true that the overburdened, inadequate, rejecting mother, who is already so anxious herself that she is unable to tolerate any demands from her children, is the kind of mother who raises delinquents, then measures which support such families and which foster good community hygiene generally will have some effect on the incidence of delinquency. It might be pointed out that this kind of syndrome can occur in families which are relatively well off economically. In these families the anxiety level is high by virtue of serious interpersonal difficulties in the family, and punishment and rejection are the chief techniques used by the parents with the children. All of those things which reduce anxiety levels and tend to foster better communication within the family and which increase the security of the individual members deserve to be considered as preventative of delinquency.

As another aspect of the prevention picture I wish to mention the very important work of Dr. John Bowlby [2] in England. It greatly merits intensive study. Briefly, he has been investigating the effect on children of separation from the mother and has dramatically demonstrated this to be a severely damaging experience, particularly for youngsters under the age of 5. Of particular importance to us is his observation that even separations of short duration produce great changes in object relationship. These changes are best seen in relation to the mother and consist, within as short a time as a week, of a period of rage followed by depression, followed by an apparent normalcy which is not normal at all. In this last period the child has difficulty in recognizing his mother and has an altered relationship to her and other mother figures. Dr. Bowlby notes that this latter response may progress to a psychopathiclike object relation, and if the separation is continued too long it may be irreversible. There is more than a strong hint here that the custom of removing a very young child from an unsuitable home may be more harmful than helpful, and the practices of many protective agencies should be examined in this light.

In a condition such as delinquency, one may have several treatment goals. Conventionally, we could schematize these goals as follows. First, without changing the integration used by a particular patient, we would like to change the content of that integration. History is replete with sterling examples of people who have used the delinquent integration in socially tolerated ways. It was not uncommon for the regular army, in the past, to swallow up ex-training-school inmates who became good soldiers. The novel, From Here to Eternity,[3] describes beautifully the way in which a delinquent culture can operate in a prosocial fashion.

A second goal of rational treatment may be to foster the use of other integrations which are already available to the patient. A boy who can make use of a schizoid withdrawal, for example, as an alternative to delinquency, may be encouraged to spend time in a forestry camp or to take up a rural occupation. It is to be noted that in these two instances there is no thought of personality change. In the first case, the patient is helped to use the same integration in a different way. In the second, he is encouraged to make use of already developed integrative tendencies of another character, obsessive, schizoid, or whatever.

In dealing with an individual delinquent, accurate diagnosis is essential. Diagnosis in this sense is a term used to describe an extensive assessment of the sources of anxiety in the individual, the techniques he has of handling that anxiety, and the circumstance in which each technique is used. We also wish to know about the constructive aspects of these techniques, as well as the disadvantages. It is quite likely that many of the youngsters coming to the attention of our courts and social agencies could be dealt with briefly, if this process were available early and were therapeutically oriented. Drs. Peck and Harrower,[4] in the New York City Children's Court, have demonstrated this by offering such a service to youngsters at the very beginning of their court experience. Of particular interest in this work is the remarkable difference in children dealt with immediately after the offense instead of after an extensive and often stultifying court experience. We need to know considerably more about the ways in which our alleged treatment efforts actually operate to make acute conditions chronic.

The greatest single advance in treatment we, as a nation, could make would consist of rapid, early, and careful evaluation of each youngster as an individual, along with a genuine, consistent effort to supply his needs as revealed by this evaluation. Schizophrenia has been defined as an acute disease made chronic by

hospitalization. One may fear that a similar situation holds for delinquency.

Changing the content of an integration may not make it completely nontoxic from a social point of view. Many social recoveries from delinquency are made in the direction of the fringe social groups, or into the nomadic occupations, and so on. These people make poor parents. They often raise delinquent children and are rarely found on the side of the angels in community affairs. It behooves us, then, to consider a more intensive type of therapeutic intervention designed to produce more extensive personality changes.

As a first step in this direction, I would like to consider at some length the emotional responses to delinquents. I am led to this for several reasons. Extensive personality change is produced, in part, by a modification of the perceptions of the patient. To the degree that treatment experiences reinforce early childhood experiences, they are damaging, or at least not helpful. They are helpful to the degree that they uncover anxiety, build more adequate interpersonal skills and integrations. An understanding of our own responses is vital to this process. Moreover, it may supply some clues to the question of why we do not generally treat delinquents, or have so many failures, and why clinics and institutions set up to treat them become restrictive and punitive or else get into some other line of work.

In terms of treatment, the potential partner in the integration is the therapist, whatever professional discipline he represents. The loose term "mental health worker" will be used here. Some of the factors which make work with delinquents difficult for mental health workers are derived from the type of personality that chooses this profession. Those of us who work in the mental health disciplines choose to do so for reasons related to our personalities. While this is probably no more true for the mental health worker than it is for bartending or civil engineering, it is particularly important in that the major operating instrument is the personality of the therapist. We are forced to be extremely interested in what this personality is like.

It is probably even more dangerous to generalize about mental health workers than it is to generalize about delinquency. I would like, however, to point to some of the motivations which, it seems to me, are particularly hampering in terms of working with an aggressive anti-authoritarian acting-out person.

The need to help might be described first on this list. It is not new or remarkable to observe that part of this motivation stems from a desire to get help with one's own problems. One of the motivations for entering the mental health disciplines certainly is such a desire. This can be accomplished fairly realistically, to the degree that one is brought closer to professional sources from which this help might be gained. On an unrealistic level, many of us try to provide patients or clients with what we feel we need for ourselves. This sort of vicarious gratification has some advantages in that it aids us in empathizing. It provides, however, very unsteady motivation for working with groups who are extremely resistant to thinking of themselves as needing help, whose own self-perceptions do not allow for weakness or for accepting anything from another. Enforced intimacy may often cause the delinquent to panic. Moreover the therapist, in tedious and unrewarding work with quite resistant cases, may often have his need to help severely frustrated. The delinquent is thoroughly familiar with the gambit that begins with "I want to do something for you," that has as its middle stage "Why are you so bad as not to let me help you," and terminates with "You are evil because you have not let me help you."

A second hampering security system on the part of a person doing therapy with delinquents might be assigned to the omnipotent-obsessional control department. Many of us are comfortable only to the degree that we can know what ails everyone around us. Our frequent lapses into jargon and assorted other intellectualizations are evidence of this. Probably this is related to anxiety stemming from our own helplessness. The use of verbalizations and intellectualizations to deal with this helplessness is a relatively neutral device if we are working, let us say, with an obsessional neurotic. I say neutral because it is clearly not therapeutic. It is, on the other hand, disastrous if we are working with an acting-out delinquent. In such cases we are apt to be frequently and nakedly helpless. Our verbal or intellectual efforts to regain control are rarely effective in these instances.

A third source of difficulty is the common tendency to use the delinquent for vicarious gratification of hostile, erotic, and sadistic impulses. Very often the obligation to be good, understanding, friendly, concerned, interested, and nice, burdens the mental health worker with the need to not notice his own hostile or sexual impulses. Being by nature people who handle things with our intellectual and verbal

apparatus, we are inevitably gratified by the behavior of a group who handle similar feelings with their motor apparatus. Out of this has grown what seems to be a dangerous myth; that is, that the delinquent does what we would all like to do. The myth is in some ways correct, but it contains an incorrect assumption. That is, that these represent not only what we would *like* to do, but what somehow, if we could free ourselves of the shackles of civilization and the restraints of our neurotic inhibitions, we all *would* do. It seems to me more correct to recognize that our neurotic inhibitions foster this hostility and sadism and do not represent simply the fetters which keep them in chains.

Another difficulty in this area has to do with the fact that often people who enter these disciplines come from middle-class backgrounds. It is often true that there are marked differences between middle-class value systems and those of lower-class, depressed, or marginal groups. Moreover, there are differences in communication systems—words have different meanings. Needless to say, one must be always alert, in an interview situation, to establish mutually agreed upon meanings and to have as explicit as possible the goal both of the interview situation and the person's life. As one moves out of one's own socioeconomic niche in society, this problem becomes more acute. This may explain why someone who had, or has, one foot in the delinquent world, often makes the best therapist.

Finally, we are often hampered by our own problems in dealing with authority and may, as a result, be extremely repressive or overpermissive with our patients. It is not at all uncommon for a mental health worker to implicitly allow riotous gratification on the part of the delinquent, meanwhile storing up tremendous hostility to the point where the relationship explodes and treatment is discontinued. It would not be unreasonable to assume that the selection of the trade of helping others, and the additional selection of that aspect of it having to do with children, would attract people who are struggling with problems of their own relationship to authority.

What do these observations mean? There is nothing new or startling in discovering that mental health workers, as well as assorted other people, are motivated in the choice of their professions by certain emotional needs and attitudes. At the same time, it is also true that one needs to be particularly alert in this field to the special kinds of motivations described above. They form part of the emotional atmosphere in which the delinquent continually lives, and which are partially responsible for his coming to grief in therapeutic relationships. The difficulties encountered in setting up treatment programs for delinquents are, I am certain, related to the above attitudes in communities and professionals alike.

A rational intensive treatment program might start, then, by choosing people who are sufficiently secure to stand the delinquent gaff. Having chosen such people, the program will support them in a variety of ways. It is wise and correct to encourage in such a group a spirit of adventurous exploration. We are nowhere near knowing all of the answers, and one should not be burdened by the need to know. All of the groups which I have seen that seemed to me to be doing a good job had such a spirit. Even under these circumstances, dealing with constantly rejecting and acting-out kids can be very hard to take. It is vital that he have constant supervisory support which helps him elucidate and deal with his emotional responses to this difficult group.

Part of the attitude expressed by the phrase "If you don't want me, I don't want you," has been dignified by theoretical statement. These are the cases which are closed for "gross social pathology." While no one can begrudge us our self-righteousness when we close a case because the client does not want help, those interested in the public weal might wonder if something else could have been done. It is worth noting that several groups have been successful in devising techniques for dealing with this extremely resistive population. I might cite the aggressive casework program which is going on in New York City, where repeated home visits are made in the face of constant rejection, and where there has been elaboration of techniques for discovering how to render those services which apparently are minimal but symbolically are extremely important. The problem of the resistant client has been attacked in other ways on the west coast [5] and also in New York City,[6] by using detached group workers to work with adolescent gangs. It does seem clear that the chairborne worker is not equipped to deal with the more demoralized client.

Social work seems to me to be a skill in its own right with a body of knowledge and techniques distinguishable from those employed in individual psychotherapy. It has a vital place in delinquency programs in its own right.

Particular attention needs to be paid to the problems of working with courts and law enforcement

officers. I am not certain that the separation between probation workers and social workers is advisable. No matter who works with an acting-out youngster, he must come to some terms with the problem of authority if he is to be useful. Passivity or covert indulgence is no more helpful than engaging exclusively in limit-setting and restriction. The addition of psychiatric services to a bad court will not make it a good court. Humanity and justice, as well as respect for the legal rights of the individual, must be a part of the legal system. A clear distinction as to the roles of diagnosis and treatment on the one hand, and fact-finding and the administration of justice on the other, is necessary.

Basically, good treatment service to delinquent children consists in providing good treatment service to all children. The tendency to build residences and training schools distant from the homes of those being served is deplorable. The observation that small, decentralized programs are uneconomical must be met with the comment that it is even more uneconomical to buy something at a lower price—in this instance, effective treatment—and not get it. Institutions which are removed from the main stream of community life are apt to become insular and self-centered. A staff working with delinquents needs to get affection and gratification somewhere, and a very strong ingroup which sets itself up as opposed to the inmates may develop if the institution does not have living ties to the community.

The concept of a defense in depth on a community level is a useful one. There is the utmost need for flexibility in dealing with the more serious behavior problems of youngsters. Perhaps this can be related most directly to the "acting-out" character of delinquency. It has been suggested in the earlier portion of this paper that the hallmark of this condition is the tendency to relieve anxiety by action which evokes rejection. It follows from this that any treatment structure must be flexible enough to cope strategically with these defenses and the accompanying anxiety. Not only is it absurd to hope to make an omelet without breaking eggs; it is even more absurd to try to make one without a bowl to catch the eggs in. It is unreasonable to ask that treatment be carried on by a worker who is constantly threatened by the prospect that some youngster on his case load will require detention facilities or a foster home which do not exist.

We have mentioned that delinquents are characterized by dependency anxiety. It follows, from this, that those working with them need to be aware of the amount of intimacy or distance possible without producing panic. A number of techniques are available for reducing intimacy in a way which is not damaging to the self-esteem of the youngster. Habitually, in his home environment intimacy is reduced by punishment or rejection, and in the community it is reduced by red tape and segregation. It is a test of the therapeutic skill of the worker that he find nondamaging techniques for "cooling off" the relationship. Redl and Wineman,[7] in their books, have described a battery of such devices. They also have described a number of techniques for therapeutic interference with unacceptable "acting out" that are invaluable. These techniques are distinguished by being ego supportive and by not repeating early traumatic experiences.

The advantage of a defense in depth becomes obvious. If treatment facilities are available on the school, child guidance, court, and institutional levels, if they are integrated with each other and to some considerable degree staffed in a free-flowing way by the same personnel, there is an opportunity for a continued comprehensive treatment program. Anxiety levels are reduced and continuity of relationship with a treatment team is maintained. It is the tragedy of our treatment services that they duplicate in many instances the pathogenic life situation. Very often, as Redl has pointed out, our treatment process consists in making someone sick, curing the sickness we have created, and then discharging him as if we had somehow effected a remarkable change in his basic problem. Increased knowledge of the way the delinquent integrates interpersonal relationships may eventually help us to stop this unhappy process.

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[3] Jones, James: From here to eternity. New York: Scribner's, 1951. 861 pp.

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[5] Robinson, Duane: Chance to belong; story of the Los Angeles Youth Project, 1943–1949. New York: Woman's Press, 1949. 173 pp.

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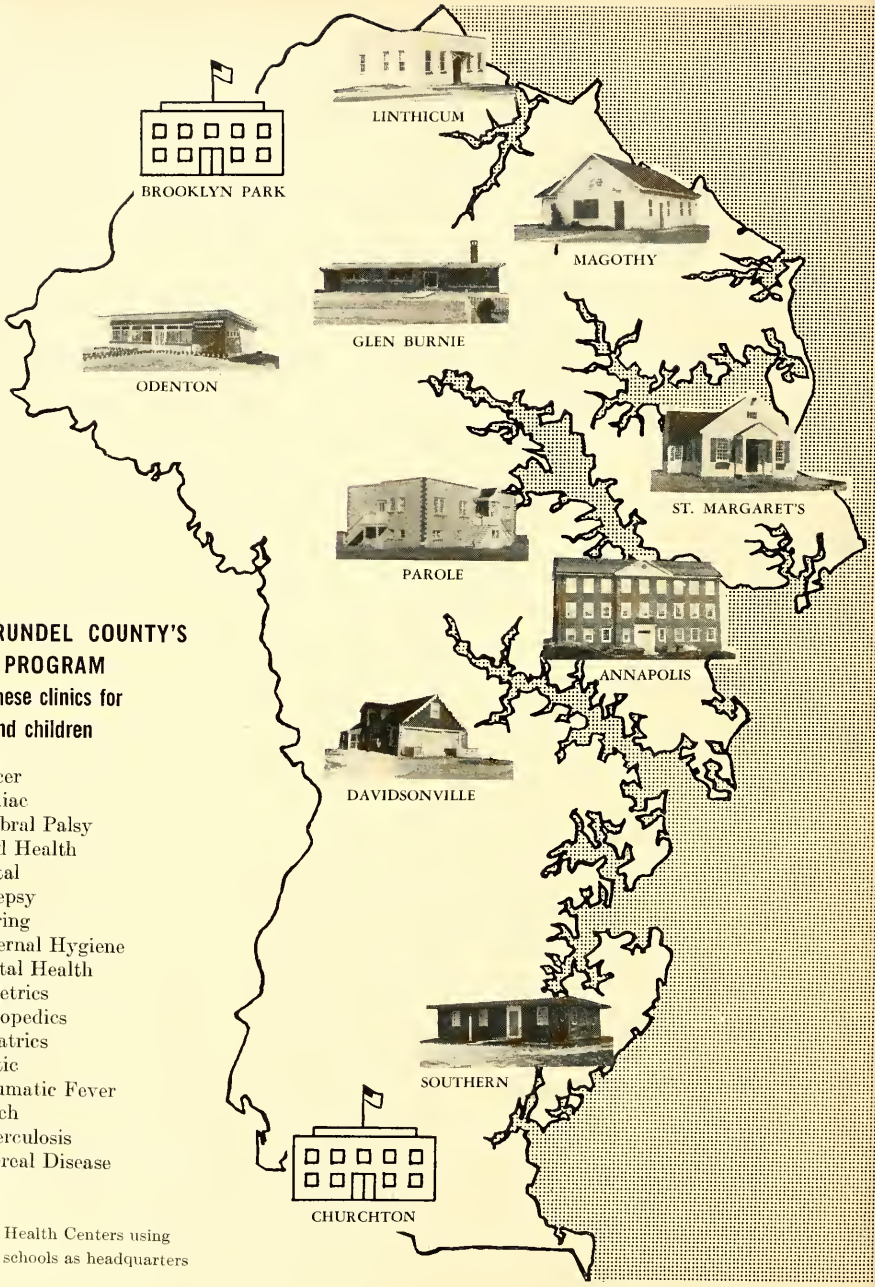

ANNE ARUNDEL COUNTY'S HEALTH PROGRAM
provides these clinics for mothers and children

Cancer
Cardiac
Cerebral Palsy
Child Health
Dental
Epilepsy
Hearing
Maternal Hygiene
Mental Health
Obstetrics
Orthopedics
Pediatrics
Plastic
Rheumatic Fever
Speech
Tuberculosis
Venereal Disease

Health Centers using schools as headquarters

Anne Arundel County, Md., proves how public health programs can function with new vigor when

CITIZENS TAKE HOLD

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as told to DOROTHEA ANDREWS

THE TRUISM that a chain is as strong as its weakest link has too long applied to citizen participation in health and welfare programs. Desultory citizen interest cannot benefit a county health program, and yet the process of arousing continuing interest and support has been a difficult and frequently insurmountable obstacle.

Yet it is recognized that one of the aims of public health is to educate. The knowledge of how to live healthily is not the prerogative of any one group. Lay workers are always potentially powerful instruments in public health education. There is no more certain way to spread information and enthusiasm than to have interested lay workers pass on their experiences to their friends and acquaintances.

In the State of Maryland, the process of encouraging lay participation has gone on successfully over the past three decades to the point where each of the 23 counties, plus the city of Baltimore, now have some degree of such participation, and each has a full-time health officer.

It is the purpose of this paper to trace the growth of lay participation in one Maryland county, Anne Arundel, where it has become a particularly effective arm of the county health department.

Anne Arundel County is a sprawling territory, largely rural in character. Its only incorporated city, Annapolis, is the capital of Maryland. Its most urban section is that which borders on Baltimore City. The median family income is higher than both the State and the national averages. There is some diversified farming, but tobacco is the major crop. The county's eastern border is the Chesapeake Bay, and the taking of oysters and fishing are major industries. About a fourth of the county's residents are Negroes.

The county serves as a State field training center. It is used for field work by health officers and others especially interested in public health who are seeking masters' degrees at the School of Hygiene and Public Health of Johns Hopkins University. It also is a training field for public health nurses studying at the Catholic University of America.

Recognized specialists from Johns Hopkins and the University of Maryland conduct special consultation clinics in the county on problems arising in the maternal and child health and school health programs and in maternal and child health clinics held by various private physicians.

The county's health program since 1939 has been partly financed by special funds granted by the Children's Bureau to the State of Maryland for maternal and child health and crippled children's services. The purpose of these special grants to Anne Arundel County was to enable its health department to show what can be done in the field of maternal and child health and care of crippled children by an intensive application of all needed public health services for mothers and children.

The county health department's total current budget is $186,617, of which $77,303 is from Federal funds. This allocation includes $46,878 for special

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purposes. The budget represents a per capita expenditure of $1.45, exclusive of the State's appropriations for medical care of indigent and medically indigent and for hospitalization. Of this total, 34.1 percent, or about 49 cents per capita, is from local taxes.

Health Program Slow to Grow

Three decades ago Anne Arundel County had no organized health services. It had a high infant mortality rate. There was a heavy incidence of diphtheria and of tuberculosis. There was no general immunization program. Health education as it is known today was in its infancy in the area. There was almost no emphasis on the importance of maternal and child health.

In 1924, through joint financing by the county Department of Education and the Maryland State Department of Health, the county got the part-time services of a health officer and the full-time services of two public health nurses.

The nurses began their work in the public schools. They found that some children came to classes each day sewed into their clothes, which were not washed from week to week. Some children were infested with head lice; some had impetigo, scabies.

The nurses undertook wholesale inspections of the children. They asked the help of parent-teacher groups in weighing and measuring them. They devised a tag system to promote physical cleanliness. Each child who was inspected received a tag with his name, age, height, and weight. The tag carried a health motto, such as "Wash your hands before eating." The children wore their tags home and, in time, began to come to school cleaner.

The nurses and part-time health officer moved to immunization.

With the help of a local physician, who was a member of the county school board, they went over the county, inoculating against diphtheria.

Again the parent-teacher groups were approached. They were told that many babies were dying simply because their mothers didn't know what good health practices were. They learned that if they could find quarters, clinics could be held, where mothers could bring their babies, and could, themselves, get help in the prenatal and postnatal period. Preschool children, too, could come to the clinics and be examined for the many childhood diseases that are common to those early years.

The first clinics were held at a desk in a local bank. Parent-teacher association members volunteered as chauffeurs to bring children to them.

A new fire department building was erected and the nurses got room on the first floor for clinic space.

The interest aroused in this program spread from parent-teacher groups to church groups, to individual citizens, and to the county commissioners. All of these groups worked, as did the Maryland State Department of Health, to get the services of a full-time health officer for Anne Arundel County. One was assigned to the county in 1930.

The health officer and the chief nurse appeared before women's clubs, parent-teacher groups, service clubs, civic organizations, to point out how the county's health program was hampered by makeshift arrangements; how communities could benefit if each had its own center for health activities.

First Health Center Donated to Community

This program of health education bore first fruit in 1937, when a well-to-do resident of the county built and equipped a health center which she turned over to St. Margaret's district, in which she lived. She also paid the full-time salary and the travel of a public health nurse for several years.

The donor made two stipulations in her gift: the center was to be used to maintain and improve the health of the community through the employment of modern public health methods; and to improve and enrich the family and social life in other, additional ways.

At the time St. Margaret's was getting its well-equipped health center, the health department was holding monthly maternal and child health conferences in the Magothy district in the home of a Negro midwife. The conferences were well attended. In the summer, women and children waiting to be seen overflowed into and filled the yard of the house. The waiting throng attracted the attention of women on nearby Gibson Island, as they went to and from Baltimore. They approached the county health officer to see if they could help to find more suitable quarters for health conferences. The health officer and chief nurse explained their need for a health center for Magothy district.

The Gibson Island women enlisted the help of men in the area. They found an empty store, whose owner agreed to rent it. They held bake sales, dances, bingo parties, rummage sales. They incorporated as the Magothy Health Association and set about remodeling the store, arranged for its finan-

cing as a center. The ladies donated furniture for the building, painted its interior, got the help of the Garden Club to landscape and maintain the center grounds, and when the health center was ready for occupancy, turned it over to the country health department. Recently the Kiwanis Club raised $1,500 to finance an addition to house X-ray equipment for the center.

The unwritten agreement with this, as with all other health associations which have been established in Anne Arundel County, has been that the county health department will use the center as a local point from which health activities can radiate, will hold clinics, and will furnish the medical and nursing personnel and some of the working equipment, that the nurse will work with the community through the center; the health association, for its part, maintains the center in clean condition, keeps it heated and lighted, and finances necessary improvements.

The growth of the health centers will be traced in some detail here, because the communities in Anne Arundel county which produced them have different characteristics and different needs. The variations reported here are believed to be characteristic of communities anywhere in the country, to which the same principle of citizen participation is applicable.

The development of each center had these things in common:

1. The venture was always privately financed, and the method of collecting funds was limited only by the ingenuity of those eager for community health service. Anne Arundel County residents have held gun shoots, oyster roasts, dog shows; solicited door to door, held dances, lunches, dinners, popularity contests; sold ads; distributed May Day baskets; distributed miniature aprons asking a penny per inch of waist measurements (some contributions were $5 per individual).
2. Each center development represented the community. A health association should represent merchants, doctors, ministers, women's groups, parent-teacher groups, service organizations, civic groups. Worthy as one organization's efforts might be to provide for the whole community, the degree to which the community will respond is going to be in direct ratio to the degree to which the community is involved.

County Health Program Adapted to Need

The composition of the communities themselves varies widely. St. Margaret's district is composed to some extent of wealthy residents, with a Negro population made up largely of domestic workers and day laborers. At the time the center came into existence, there was a high incidence of tuberculosis and of premature births among the Negroes. The Negroes have used the center to a great degree, while the white residents, for their part, have financed center developments. Probably because of their high economic status they have not used the center. A health association to finance the maintenance of the center was established in the middle 1940's. Up until that time, the center was financed by its original donor. Recently a Negro was named to the board of that association.

In Parole, where the population is predominantly Negro, the move for a health center was partially sparked by an elementary school principal who believed "every child has a right to be born a healthy child." He told his parent-teacher group that many children were being denied this right because of inadequate prenatal care.

Leaders in the community soon were pitching in to convince the citizens of Parole that the health department, operating from its tiny and makeshift quarters, could not provide the service the community needed, but, given adequate facilities, was ready and willing to expand that service.

Contributions and support came both from white and Negro residents of the area. A center was finally constructed a few years after World War II. Because most citizens of Parole must watch their pennies carefully, the health instruction given to parents is always carefully geared to their resources. They see how an empty fruit crate can be converted into a baby bed, how a crib pad can be lined with newspapers.

Partly at the instigation of the Parole Health Association, a series of five lectures on public health is given annually to students at the Negro high school by members of the health department staff. Ground work laid by the school faculty has added to the success of the course. Chest X-rays and blood tests are given in conjunction with the lectures, to emphasize the importance of health examinations for the students. Any student who needs medical attention is referred to his family physician and his case is followed up by the health department.

Wartime Industrial Expansion a Factor

At Glen Burnie, the need for a community health center was brought into sharp focus during and after

World War II, when a great many people moved in to work in industrial concerns in and near Baltimore.

Preschool "roundups" and maternal and child health conferences, held by the county health department in a room in the local Masonic hall and supported by the health association, were demonstrating what a health program could give the community. Glen Burnie's Health Association, with the aid of the Glen Burnie Improvement Association, convinced the community that a health center was a necessity. The school board deeded a site. With some $50,000 that they raised, the association built one of the largest and most completely equipped centers in the whole county. A wide variety of health activities is being carried on in this center.

At Odenton, clinics were held for many years in the home of a Negro midwife, later in the basement of the local school. In 1943, a plastics manufacturing company moved into the Odenton district. Its president began to take an interest in the center. First he paneled the rough walls in the basement clinic. Subsequently, he offered to make a substantial contribution if the Odenton group was interested in building its own center. Some local residents donated land and the plastics firm erected a center, at a cost of $50,000, which was turned over to the local health association.

Nurses at the Odenton Health Center also cooperate with the nursing staff at nearby Fort Meade, who care for dependents of military personnel. When patients, largely maternity cases, are released from the Fort Meade hospital to homes in the Odenton district, they get postnatal followup care through the Odenton center.

Outbreak of Disease Spurred Health Efforts

In southern Anne Arundel County, where not 1 community but about 10 "country-store" areas were to be served, community support for a health program was slow to develop. One factor in the lag was that clinics were being held in one of the "country-store" areas, and that residents of the rest of the section felt this was not "their" health program.

It took a case of typhoid fever, after which between 600 and 700 area residents sought immunization at the clinic, to arouse community fervor for better local health facilities. A Lions Club took the lead, aided by some indefatigable women in the community. Foundations were dug and walls erected by free labor. The new center is located between communities, and is now enthusiastically supported by southern county residents.

At Davidsonville-Mayo, a local health association set up its first health center in an abandoned store in the most primitive of surroundings. The services of a neighborhood carpenter were enlisted to build a privy; men in the association tacked up beaverboard partitions in the center; an oil stove was brought in to heat the building. Within the last year, ground was broken for a new one-story health center which is being constructed at an estimated $6,500 cost, all locally raised.

Brooklyn Park, which borders on Baltimore has had an extremely heavy influx of new residents. Starting in the late thirties, the newcomers created many problems for the health department. Some had to be cajoled to bring their children to child health conferences. It was only when a case of diphtheria was reported in the area and an epidemic was threatened that some parents were persuaded to have their children immunized and vaccinated. A health association has since been formed, and now operates a health center which is housed either in an elementary school or a firehouse, depending on the weather and whether school is in or out. The board of education has agreed to give the health center quarters in a new junior-senior high school now being built. To equip its new space, the association has raised about $10,000. Health officials, in addition to their regular services, hope to use this center in a demonstration project for health services for the older school-age child.

The South Shore Health Association, also, is without its own center. Clinics were first held in a church, but through the cooperation of the health and education departments are now held in the Millersville School annex.

Health Associations Have Similar Setup

As now constituted, the health centers provide full geographic coverage of the county. Each center is manned by a full-time senior nurse, who usually has an assistant nurse to help her.

The organization of these local health associations varies from district to district, but the purpose stated by the Southern Anne Arundel association's bylaws is the general pattern of all:

"The purpose of this association shall be to establish and maintain a health center with suitable headquarters to create and foster a community consciousness in the area served, to lend assistance in proper

health and welfare work, and to cooperate with the county health department in all matters for the betterment of the community."

All but 2 of the 10 groups finance their operations by raising funds in the community. The exceptions are the Odenton Health Association which recently voted to join the community chest and the Parole association, which is still paying off a mortgage, and receives partial support from the chest.

A monthly association meeting will include a discussion of financial status and a report from the nurse who is in charge at the center. Her report is a recital of what has gone on since the last meeting, but may also include a plea for more equipment or point to the need for association action for the community.

Health Centers Not Sole Community Interest

The interest of one lay health group was stimulated to find how many handicapped children lived in the county. This information was turned over to the health department, and arrangements were made to form a special class to teach children with cerebral palsy.

Classrooms and teachers were provided by the county board of education, while the health department provided an orthopedic specialist, a speech therapist, and a medical social consultant. A lay association of mothers of spastic children and other individuals transports children and furnishes special schoolroom equipment. It also operates a nursery school, to prepare crippled children for entrance into regular school classes, when they are ready.

More than 100 active volunteers are working in some capacity in the county's health centers. Others are working in the schools. They are trained by members of the health department staff for their jobs, and understand that by volunteering they free the nurses to devote more of their time to nursing duties.

They have taken over such duties as weighing patients, keeping record cards, helping patients dress and undress, acting as receptionists in the centers.

In the schools, special teams of lay workers have been taught to help in the testing program. One volunteer, herself a graduate nurse, does electrocardiograms. Teams have been trained in vision testing, in using audiometers to test hearing, and in working with spastic children. During the 1952–53 school year, for example, 96 volunteer workers gave 1,642 hours and screened 7,932 children in hearing tests. They found more than 500 children who needed further testing to determine whether their hearing was normal.

Civic groups in the county also have been active in the health program. The Lions Club in almost every community has a fund to buy children's glasses, and many of these clubs also are buying shoes. The Odenton School PTA supplied a dentist, working out of the health center, to care for the teeth of children in the lower four grades of the elementary school. The Kiwanis Club arranged to finance a dental clinic when State funds were limited. The homemakers clubs take on centers as their "project," to supplement the association's work. The Glen Burnie Kiwanis Club recently started a "loan closet" with an invalid's chair for community use, and has asked for other similar contributions to the center. The Christ Child Society each year buys Christmas presents to be distributed through the center to its needy patrons. The League of Women Voters and the Women's Club of the county cooperated with the county health department in sponsoring the first institute on venereal disease ever held in Anne Arundel County. Both the local chapter of the National Council of Jewish Women and of the Order of the Eastern Star have purchased audiometers. This list is not all-inclusive.

Lay Council Coordinates Community Program

The Anne Arundel Lay Health Council, which was created in 1946, serves a dual function: it is the medium through which members of the health associations exchange information on programs and future plans; it is advisory to the health department, and is kept informed by the department of its program and needs.

Represented on the council are members of each local health association, of voluntary health agencies, such as tuberculosis associations, mental hygiene, cancer, heart, etc., of parent-teacher organizations and other civic organizations, and individuals interested in promoting health in Anne Arundel County.

This council is a recognized and respected spokesman for the community on its health problems. It paid the salary of a part-time replacement for a nurse so she could get additional training at the University of North Carolina, and successfully laid before the Anne Arundel County commissioners a plea for funds for five additional new public health

In Anne Arundel County's health program, which is strongly mother-and-child centered, 1,011 infants and 1,984 preschool children were seen in clinics in 1952. In addition, 1,898 school children were examined by physicians, and inoculations against diphtheria were given to 4,209 children, and against smallpox to 823.

nurses for the health department. When it appeared that the State legislature might reduce the amount of the medical care appropriation available for the care of the indigent, the lay health group aided in obtaining action against the cut.

When the health department proposed to Annapolis city government heads that fluoride be added to the city water supply, the council, fully advised of the way the plan worked elsewhere and of its benefits in the prevention of caries, supported use of fluoridation.

The council also has supported the health department program directly. From its earliest organized activity, the department had been housed in makeshift quarters. It had space in various public buildings, was subject to both moves and evictions. The desperate need for permanent headquarters, also housing a health center for Annapolis, was repeatedly emphasized both to the council and to other community groups. The chairman of the lay health group and a representative of the county women's club made a joint broadcast urging public support of an Annapolis center. The women's club turned over their own building fund to help finance the structure, and the council supported plans for a building bond issue for the building. With local, States, and Federal aid, a new health center was erected in Annapolis early in this decade.

The council, and its member associations, are kept advised, not only of health department problems and community "projects" but also of new medical and scientific advances which, if everybody works together, Anne Arundel may have.

Health Department Draws on Other Resources

The health department also works closely with four other community-focused advisory committees:

1. The medical advisory committee of the county medical society, a liaison group with whom programs involving medical services are discussed, as are problems of mutual interest to private practitioners and the health department.

2. The medical care committee, composed of representatives of the medical, dental, and pharmaceutical professions, the welfare department and the lay health council. This committee keeps abreast of developments in the State program for the care of the indigent and the medically indigent.

3. Council for Services to Children and Families, composed of all official and voluntary agencies providing any service for children in Anne Arundel

County, including the health and welfare departments, board of education, the Salvation Army, the Red Cross, the Association for Crippled Children, the Lay Health Council, parent-teacher organizations, and the juvenile court. This council correlates children's services and studies ways in which they can be expanded or improved.

4. Health-Education Council, composed of representatives of the county health and education departments, the schools, the Lay Health Council, and the county-wide parent-teacher association. This council formulates the program of school-health services and keeps abreast on their current operation.

The school-health program which the council oversees and which was jointly agreed on by the health and education departments is beamed at total health evaluation.

The aim of the program is twofold:

1. To develop an educational program consistent with each child's physical, mental, and social potentialities and capabilities.

2. To determine at the earliest possible time, the development of disease or disability.

The emphasis in mental health aspects of the county health program is to find emotional disturbances in children at an early age, and to intercept and alleviate the factors which cause these disturbances.

Wide Variety in Current Health Program

From its very humble beginnings in the schools, and because of all the factors cited in this paper, the Anne Arundel County health program now has grown to include the clinics cited in the map accompanying this article. In addition, a continuing study is being made of premature infants, and the health department is participating in a State-wide study of home accidents.

Citizen participation has played a vital role in the development of this program, but it has not yet reached the millenium in Anne Arundel County. There are still some people who do not use health center facilities, nor join in health association activities.

On the other hand, public health in Anne Arundel County today is not just organized community effort expressed through an agency doing something about health, but an organization of the public themselves, with the aim of abetting and aiding their own health.

The health program itself is not impervious to change. It should be possible, without departing from current programs, to expand the program into the problems of the aging, into providing general rehabilitation and into the diagnosis of other specific disease entities.

The health officer must carry much responsibility for the solid development of community participation in community health, but no health officer can do the job by himself. He must have solidarity in his staff, an understanding and enthusiasm among them for the job to be done.

This understanding and enthusiasm must also infect the community but the community must be allowed to participate at its own pace and in its own proportions. As one of the public health nurses has put it: "You can't ask them to do too much at one time, but on the other hand, you have to have something new ready for them to do as soon as they finish the task at hand; otherwise they lose interest."

As long as the health department maintains a vigorous leadership in all professional matters, the public will welcome that leadership. The average layman looks to the professionally trained person for guidance on matters in which he has little technical information.

The numbers of people who need to be drawn into a lay health group in order to make it function need not be large. They must, however, represent a nucleus of the community, a cross section of its life, ready to enlist their neighbors, friends, business acquaintances in something they are convinced is good. As one community leader put it, "The more people you can talk to, and get on your side and let them do the talking for you later on, the better off you are."

A county health department should be like an old shoe to the people it serves.

It must fit. It must be maneuverable. It must be something the people are comfortable in using.

Recognition of this fact has helped build a solid structure of citizen participation in a county health program in Anne Arundel County, Md.

CASEWORK WITHIN AN INSTITUTION

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CASEWORK WITHIN AN INSTITUTION is the application of basic casework methods to the institutional setting. Like any other form of casework it has a dual orientation: (1) to discover, diagnose, and if possible change the factors within the environment that lead to maladjustment, and (2) to discover, diagnose, and change the factors within the individual's personality that lead to maladjustment. Like casework in other settings, institutional casework can be successful only if the client wants to be helped, and if the caseworker can establish a relationship with him. Institutional casework is no more able than any other type of casework to change some of the major sociological, economic, and psychological causes of maladjustment.

In many ways casework in an institution resembles casework in a child placement agency, in a child guidance clinic, in hospital and other settings. As in all placement work, intake is a very important and crucial part of the casework function. The decision to place a child away from home, the decision to place a child in an institution rather than in a foster home, and finally the preparation of the child and the parents for the placement are of paramount importance.

As in all placements, the casework must be done on two fronts—with the child, and with his family. Although separation is a reality, reunion with the family must be a potential goal. We have learned through years of experience that it is easier to take the child away from the family than to take the family away from the child. As a matter of fact, for the average child in latency and adolescence it is well nigh impossible to replace parents in his imagery and ideation. Therefore, an early diagnostic recognition of the family's potential and its ability to take the child back is a necessary condition if the child and the family are to be helped to achieve this goal. On the other hand, an early recognition of the family's inability to be reestablished as a total unit is necessary so that no confusing detours will occur which would delay the child's settlement in a substitute family group. Too many institutions keep too many children for too long a period of time because somewhere along the road the correct diagnostic decision about the family's ability to take the child back was not made. Rehabilitation of the family, if it is to move along concurrently with treatment of the child, involves intensive help to the parents, so that they may resolve the pathology that led to the difficulty in the parent-child relationship necessitating placement and at the same time recover from the ego deflating experience and recreate their feeling of adequacy as parents.

Specific Factors in Institutional Casework

Perhaps the most obvious characteristic of institutional casework is that the children in treatment are always available, that they can be observed not only by the caseworker but by other staff 24 hours a day. Institutions, therefore, lend themselves to a more thorough study and possibly to a more direct form of treatment than other settings.

Another characteristic is the fact that all children come against their will. The fear of every child of being rejected and being thrust off by his parents has materialized for all children in the institution. They are unable to deny the fact of being placed away from their home and must come to grips with the problem of parental rejection. Since the problem is universal in this setting, it can be handled more easily.

Finally, going to the caseworker or to the psychiatrist is not a privilege, a duty, or a stigma imposed upon the individual children. Instead it is a common pattern in an institution, and so the therapist meets less initial resistance here than elsewhere.

The work of the caseworker in the institution can be best understood if we consider the 4 major concepts upon which her work is based, and the three major functions which the caseworker in the institution must fulfill.

Concepts of Team, Purpose, Time, and Authority

Team

Institutional casework is teamwork. The classical child guidance team consisting of psychiatrist, psychologist, and caseworker is also the core of the clinical treatment of the institutional child. In a more particular sense the consultation team between caseworker and psychiatrist plays a very intensive part in the child's treatment. The implications of the relationship between caseworker and consultant psychiatrist, its effect on the treatment of the child, on the development of the caseworker as a professional person in his own right, have been discussed frequently in professional literature by both caseworker and psychiatrist.[1] Although it is not unique to the institutional setup, there are several specific characteristics of the team in the institution.

One is that the team is composed of multiple professional disciplines and specialized lay practitioners. Secondly, it is a rather shifting team, and therefore, membership is not static.

There are three levels of teammates: (1) the people whose assignment is to work directly with the child, such as caseworkers, cottage parents, teachers, and recreational workers; (2) the group of people whose assignment is to work indirectly with the child, the casework supervisor, group work supervisor, administrators, and principals of schools. The psychiatrist and psychologist fall in either of these two categories. (3) There are the people whose assignment to children is not predetermined, such as the cook, truck driver, gardener, or the farmer.

In all this the caseworker is the coordinator. She must be aware of the roles which the child assigns to the many adults with whom he comes in contact, and must help those individuals fulfill those roles as constructively as possible.

It is the child, for instance, who determines which adults he selects to be his confidants, and it is he who chooses whom he will invest with parental qualities. It may be the cook, the gardner, stenographer, or it may be one of the extramural teammates.

It is very important that the team have an opportunity to work together and plan together. One of the most important relationships in the team is that of the caseworker and the cottage parent. Caseworkers must see that they do not become "supervisors" of cottage parents, and also that they do not become "caseworkers" of the cottage parents. The total staff must have the feeling of mutual participation. If the cottage parents feel that all major decisions have already been made by the clinical staff and the administration, and that their presence at conferences is more or less a courteous democratic gesture, they will never really become a part of the team. This does not mean that everyone should become an expert on everything, but that everyone should participate to the degree of his own expertness. The caseworker has to be sensitive to everyone's desire to make his own unique contribution to the development of the child.

Purpose

A constant awareness of the purpose for which the individual child has come to the institution is necessary. The diagnostic intake process must be the basis of a treatment plan which establishes the purpose of the child's coming to the institution, and the steps to be taken in order to achieve this purpose. The caseworker must have this purpose constantly in mind, and relate all experiences of the child in the institution to this plan. The stay in the institution very often doesn't make sense to the child, to his family, and frequently not even to the untrained institutional staff. She must constantly reexamine the ways in which the institutional program is affecting the child, and must be alert to the need for and possibility of changes in program to facilitate his adjustment and treatment.

Awareness of the purpose of a child's coming to the institution throws a light upon the meaningfulness of all his experiences within the institution. Although a number of principles have been established as to which children can best benefit from institutions and which cannot,[2] still there are many children who stay in county homes, shelters, and all types of institutions for no other reason than their dependency, and for no other goal than to grow old enough to live on their own. This is almost completely contrary to the modern concept of the pur-

pose of an institutional residence which is to treat the child, to help him as quickly as possible live in a family in the general community.[3]

Time

Because the institutional setting in our society is an artificial one in that it does not provide the child with the intimate relationships necessary for healthy growth, institutional placement should be as short as possible as well as being geared to a very specific purpose. The time, of course, depends on many factors and varies for each child. The caseworker more than anyone else, however, must be aware that time and purpose cannot be separated, and that time is a very important tool in helping the child and his parents best utilize the institutional opportunities. It is important for a child to see how much he has accomplished in a given period of time and to set a time in which to achieve other developments.

Granted that it is not possible to predict any part of the child's adjustment at the institution, or the time it will take, it is certainly possible to review it. Frequent evaluations in which the caseworker takes a leading role, interpreting the child's development, restating the purpose of the placement, and judging how profitably the time was used are necessary.

At Bellefaire we have found the semiannual evaluations of every child, in which every staff member working with the child participates and in which the projected length of stay is an important question, are not only helpful but essential in assessing progress and clearing future goals. Such periodic evaluations can be used purposefully in direct work with the child. The caseworker can, for instance, inform the child about the forthcoming evaluation conference and help the child to evaluate himself. How much have we advanced by now? How far do we still have to go? This is especially helpful with the adolescent who has insight and who shows at the same time a great restlessness and impatience in relation to his leaving.

Actually the question of time is in the foreground of the mind of almost every child in an institution. "How long do I have to stay here?" is probably one of the most frequently asked questions. Usually caseworkers have to be evasive about answering this question. Yet some partial answer can be given if one can relate purpose and goal to time, and if one helps the child see how far he has gone in relation to the length of time he has been in residence.

Parents are invited to participate in the thinking preceding the conference, especially those parents who have conscientiously participated in the intake process and in the treatment plan, and those whose anxiety is aroused by the child's problems, and who are going to great personal sacrifice to send their child to an institution. Progress reports at regular intervals are important in sustaining their cooperation and participation. It has also proven beneficial for those parents who would like to use the institution as a more or less permanent placement for their children, who are ready to remain "Sunday afternoon parents," and who can only be helped to take responsibility if they are given time limits for placement.

Authority

Since institutional treatment is involuntary as far as the child is concerned, and has definite educational goals, the concept of authority is inseparably connected with it. The caseworker is identified in the eyes of the child with the authority vested in the institution. It depends on the diagnostic need of the child, and the organizational setup of the agency, as well as the caseworker's own ability, what share of the total institutional authority she can assume. The question whether authority helps or hinders in a treatment relationship has been of concern to all therapists.[4] It can easily become confusing to the caseworker in an institution.

Some caseworkers identify authority with punishment and resist the assumption of authority not only on their own, but also on the part of other people in the institution. Other caseworkers are ready to assume authority in some areas (granting of privileges) but refuse to do so in others (denial of privileges). Some administrators are unrealistic in the delegation and distribution of authority among their staff, and show little understanding of the caseworker's treatment role and its effect on her ability to assume authority.

Diagnosis and treatment plans for each individual child must be the criteria for the total amount of authority the child needs in the institution, and for the part the caseworker can exert directly. The organizational effectiveness of the total treatment plan must, of course, for the caseworker, as well as any other member of the staff, be a guide in the assumption of authority, so that her function does not interfere with the assignment of others.

Functions of the Institutional Caseworker

Having these concepts of team, purpose, time, and authority in mind we see three main functions of the institutional caseworker: (1) her role as an interpreter; (2) her role as an integrator; (3) her role as a therapist.

Interpreter

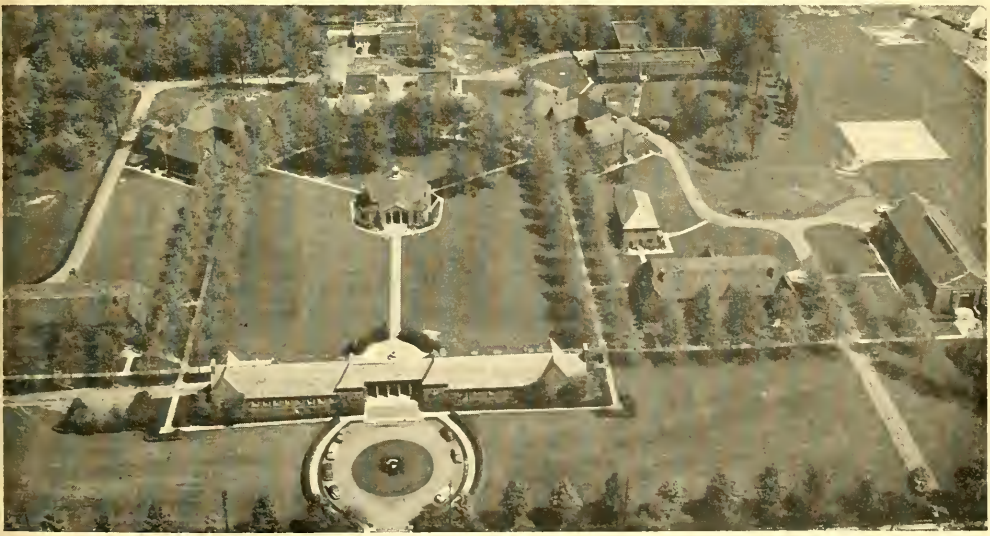
As an interpreter she works with people in the environment. She interprets the child to his present and his future, to his intramural and his extramural, environment.

A part of the interpretation must be given to the parents if the child is to return to them. She helps people understand the causes of the child's behavior and the purpose of the child's treatment. The more understanding people have of behavior, the better they are able to accept it. The untrained institutional staff, too, usually needs a good deal of help in understanding the mechanism of projection and the child's need to express hostility. The more people can be helped to see that hostility is not directed against them personally, that they are more or less incidental targets of repressed feelings of hostility really directed against somebody else, the less they are apt to develop counter-hostility, and the more they can see that there might even be some good in the expression of hostility.[5] It is, of course, much more difficult to do this with the parents of the child, not only because they are part of the cause of the behavior, but also because frequently they are the victims of the very same causes and their defensiveness and inflexibility often makes them inaccessible to this type of interpretation. Yet, if we want to be successful with children, we have to interpret them to their parents so that the parents can live up to their role, however small it may be. This interpretation to parents has to be part of the treatment program itself.

Finally, the caseworker must be the interpreter of the individual child to the other children. This usually can be done indirectly through the cottage parents who prepare the group for the arrival of the child and for special problems which the child may present.

In this, as well as in all other forms of interpretation, it is important that the caseworker discuss what is good and attractive in a child and as well as what is disturbing.

Bellefaire's children live in eight cottages, each with its own dining room, kitchen, living, and play rooms. The plant, located in a residential area on the outskirts of Cleveland, also includes an administration building which houses a library, arts and crafts room, and woodshop; Alumni Hall, with gymnasium and swimming pool; and chapel.



Integrator

Institutional staff members want to know not only why a child acts the way he does, but also what role they can play in order to help the individual child. The child has a storehouse of opportunities available to him at the institution. While it is not the caseworker's function to provide and assign the jobs to the staff, it is the caseworker's role to help the individual child to utilize staff members at the right time, and to help people let themselves be utilized in the most constructive way by the child.

The total program of the child is the caseworker's concern because in a broad sense everything in an institution is treatment: the general atmosphere, administrative philosophy, group living process, school, recreational program, work program, discipline, visiting policies, and the rest. The whole institution must provide a "therapeutic milieu"[6] if any single service of it is to become an effective treatment tool. While the caseworker cannot determine the structure and policies of the institution, she does have the responsibility to bring to the administration, through the proper channels, information that points to the effectiveness or ineffectiveness of the program. The supervisor or a proper representative of the casework department should be a constant advisor to the administrator to keep the program flexible and therapeutic.

While institutional programs have to be periodically reexamined and improved by the administration, the staff and children have to accept the present program as reality. The individual caseworker has to work within the program as it is, helping the child to utilize it to the optimum.

Therapist

Important as is the environment in an institution, the physical and general emotional climate is only a part of the treatment program. Essential to emotional reorientation and personality change is the relationship with a person able to function in a therapeutic role.

At Bellefaire most of the direct treatment is done by the caseworkers. The psychiatrists participate in intake decisions and see every child within the first 3 months of his stay at the institution for diagnostic interviews. About 10 children receive direct treatment by the psychiatrists, four of them in analysis. All the other children are seen by the caseworker in weekly or semiweekly interviews. The caseworker has weekly consultation with the psychiatrist.

In the treatment relationship the caseworker uses mainly interview techniques in order to sustain the child's ego, to clarify his confusion about his outside realities, to help him look at his present self in relation to his past experiences. On the basis of her diagnostic awareness of the child's needs, she permits him to express anxiety about his inability to cope with the reality, or hostility toward the people who represent the reality. The worker permits the treatment relationship to become a microcosmic measure of the child's experiences and potentials in relationship to other people.

There are 2 basic goals of therapy with the institutional child: (1) an increase in his social adaptability; (2) the development of insight. These 2 goals are usually mutually interdependent. The child recognizes the caseworker as someone who is different. She does not overtly participate in the directing and value-setting activity of the rest of the institution. Seemingly she remains neutral in the struggle of the child against the institution's values and routines. This permits the child to invest her with those qualities that he needs to see in her and to identify her with people in his life in idealized or distorted images. Thus she may represent a protective mother today and a pushing one tomorrow, an "ally" against the rest of the institution now and a "stooge" of the administration then. While she allows herself to be used in these different roles, the worker's efforts are directed toward the strengthening of the ego and superego of the child. Encouragement, suggestions, support, anticipation of and aid during crisis situations are her major techniques. Only reluctantly is the child willing to look into himself and trace his problems back to their origin. Only slowly is he able to give up some of his pathological defenses. Helping a child give up defenses is hazardous and should not be undertaken without the consultation of a psychiatrist.

Contributing to this hazard is the fact that in an institutional setting there are so many individuals, cottage parents, cooks, counselors, and gardeners whom the children can use as "therapists." This happens quite frequently when the child develops resistance against treatment and hostility against the caseworker or when his anxiety is so overwhelming that he cannot contain it. At such periods flexibility in timing and frequency of casework contact is essential. Skillful handling of the rest of the staff is necessary in order to help them steer the child to the caseworker rather than to compete with her. Equally important is the caseworker's ever-avail-

ability in crisis situations in and outside her interviewing room. This is one of the unique assets of institutional casework.

It is, of course, unavoidable that children become "therapists" to each other, and in this way reduce or create anxiety. They compare their individual caseworkers and they certainly are among the caseworker's severest critics. This might have an effect on the individual child's relationship to the caseworker. However, this and other difficulties arising from the setting can be handled by the alert caseworker with the child and can often serve as a help rather than as a handicap in therapy.

One word about work with parents. Institutional casework is not complete without casework with the parents. Yet in practice there are a number of handicaps. A great number of parents do not want treatment, or are inaccessible, or are too disturbed for casework help. Often parents need more help than an institutional caseworker can possibly give. We believe that the main content of the contact with the parent has to be the development of the child and the parent's reaction to him. It happens frequently that this reaction is determined by the parent's own pathology. While the caseworker can help unearth the cause of this pathology, it is not always possible for the institutional caseworker to treat it. In some cases where actual rivalry for the caseworker exists between the children and parents, or in cases of great hostility and severe rejection, the assignment of a separate caseworker to the parents may be indicated. In other cases the referral of the parent to an agency which can help him separately and a close cooperation with that agency are necessary.

At this time there seems to be little experience in successful treatment of parents of children in institutions. This is perhaps because until recently institutions tried to keep parents as far away as possible.

During the past years the total field has become aware of the fact that parents of disturbed or dependent children are "troubled parents" who look at themselves as failures as parents and feel stigmatized.[7] Many a teacher, neighbor, and judge hammers into them again and again that they are failures. Social workers can try to show them that with all their failures they had at least one strength, namely, to do something positive for their children by coming to the agency.

Summary

Casework in the institution must be an integral part of the total institutional program. It cannot be something which is superimposed from the outside. Casework in the institution is generic casework applied to the institutional setting. The concepts of team, of purpose, time, and authority, are basic. The functions of the caseworker as an interpreter of the child to the environment, an integrator of the environment for the child, and a therapist, require maturity and skill. It is essential that institutions look for this skill in their casework service.

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through its aid, scores of countries have made permanent gains for their children

UNICEF UP TO DATE

MAURICE PATE

Executive Director, United Nations Children's Fund

THROUGHOUT THE WORLD, from Brazil to Burma and Liberia in the heart of Africa, millions of children are leading happier, healthier lives partly due to the activities of a United Nations agency which is concerned with their welfare. The agency is UNICEF—the United Nations Children's Fund—which today is helping 75 countries in Asia, Africa, the Middle East, and Latin America make the world a better place for children to grow.

UNICEF contributes powdered skim milk, vaccines and insecticides, medical and other supplies which underdeveloped countries can't afford to import. With this help, and with technical guidance where needed from the World Health Organization and the Food and Agriculture Organization, governments are bringing a greater measure of health and well being into the lives of children than they, or generations before them, have ever known.

In Qassemia, for example, a village on the edge of the Damascus oasis, the 350 inhabitants have just spent their first year without malaria. Before Syria's UNICEF/WHO-aided campaign brought DDT sprayers into every adobe dwelling of the village, 7 people in 10 were down with malaria each year. Now, for the first time in memory, there is no malaria.

Thousands of miles eastward, in the modest home of Francisco Bautista in the Philippines, the small living room and kitchen is crowded every week with mothers and babies, nurses and trainees, a pediatrician, a dentist, and a records clerk. Asked by a UNICEF observer why she put up with the inconvenience of having her home disrupted, Mrs. Bautista replied: "In nearly 2 years since they started coming here no mother and no baby has died. Before that . . . ." She shrugged her shoulders expressively.

Before that, rural health workers were virtually nonexistent, and people had nowhere to go for medical help. Then, with just a few thousand dollars of UNICEF aid, the Government set up a center that is training more than 1,100 workers and making possible the lifesaving activities that take place every week in the Bautista's house and in more than 1,000 health centers throughout the islands.

Whether the country is Syria, the Philippines, or Guatemala, the target malnutrition, malaria, or tuberculosis, the story is the same. Governments of underdeveloped countries want to rout the ills which have afflicted their children for centuries. United Nations aid is sparking a significant start.

The World Health Organization and the Food and Agriculture Organization send experts to lend technical guidance. UNICEF sends supplies when governments can match their value with local goods and services. Far more than matching UNICEF aid, countries are stretching limited budgets to spend, on an average, $61 for every $39 put up by the fund. As a result, the lives of tens of millions of children have got off to a better start.

One of the most important ways in which UNICEF is aiding underprivileged children is by helping governments build up basic health services. In most of the world's rural regions, mothers and children have never had access to medical care; doctors and nurses are almost unknown; ignorance takes a high toll. Today, UNICEF is providing equipment and medical supplies for about 5,700 maternal and child welfare centers, and it is helping governments train nurses and midwives to staff them.

In Asuncion, Paraguay, an investment of $80,000 by UNICEF has started a spectacular chain of

events that is already beginning to deliver good health to thousands of children, who, up to now, have had only 1 chance in 3 of surviving.

The first of a group of health centers built by the government, equipped by UNICEF, and staffed under the guidance of WHO, opened less than 2 years ago in the small (5,500) community of Fernando de la Mora. The clinical work is in the hands of young, competent physicians. Its equipment, from sterilizers to examination tables, is the most efficient obtainable. There is a UNICEF ambulance to take patients who need hospitalization to Asuncion. Seven hundred mothers have already registered.

In addition to medical care, the clinic offers many "extras." Here an expectant mother learns to prepare a new baby layette that costs as little as 90 cents. The clinic's prenatal Mothers' Club teaches her how to sew. It also gives a course of 7 weekly lectures on such vital subjects as nutrition and control of infant diarrhea, each lecture followed by an appropriate movie. This is the mother's first contact with scientific health principles.

After her baby is born, she joins another of the center's clubs. Here she encounters, also for the first time, the fundamentals of healthful homemaking.

Many communities besides Fernando de la Mora are benefiting from the activities of this clinic. The core of its work has been training personnel for other centers, and for a new children's hospital, also equipped by UNICEF. A number of nurses and midwives have already been trained and are now at work. Others will follow.

And there is more to this remarkable little health center. Largely through the monumental energy of WHO Health Education Director, Dr. Rigoberto Rios, it has touched off a series of unexpected activities. Because of the community interest in health and education that the center aroused, Dr. Rios was able to organize a series of fiesta benefits that have raised money to build a large public market in the town and to set up a kindergarten, the first in the country. Here, working mothers may leave their children, and young women are being trained in handling groups of preschool youngsters.

Spurred by these successes, Dr. Rios tackled the local school problem. There were facilities enough for only 500 elementary school children, with 1,300 potential pupils. Building around the health center group, Dr. Rios organized another series of benefits—a horse show, football games, and a fiesta—for the Ministry of Education. When he counted up the profits, he had $3,000—enough to buy land for 6 more schoolrooms—and a promise from the Minister of Education to construct the buildings. They opened last year.

What this little seven-room health center has brought about is quite an accomplishment: a prenatal clinic, a homemakers' club, an enlarged elementary school, a kindergarten training project, a public market, and staff for a new children's hospital. And in Paraguay alone, there will be 10 such beehives of health activity soon.

Through UNICEF-aided maternal and child welfare centers, millions of children are being reached and will continue to be reached after UNICEF assistance ends. This is also true of other types of UNICEF-aided projects, for, except in the case of certain emergencies, the fund extends assistance only for a limited time and for programs which will continue to benefit mothers and children for many years.

Besides providing supplies for basic health services, the fund is encouraging long-range planning in a second way—by aiding campaigns against disease. Those diseases which afflict the most children and can be combated at comparatively low per capita cost

Every week, a traveling health team sets up mother-child clinic services in a private home near Quezon City, the Philippines. Outfitted by UNICEF, the team conducts everything from nutrition lectures to competent dental treatment. Since 1951, UNICEF has provided supplies for 500 such mother-child clinics which have improved services reaching 1,500,000 mothers and children in the Philippines.

are the targets—principally malaria, tuberculosis and yaws.

Yaws, a disease unknown in the United States, strikes an estimated 50,000,000 people along the torrid belt between the Tropics of Cancer and Capricorn. This horrible affliction causes boils on the body, then on the soles of the feet and the palms of the hands so that its victims cannot walk or work. Finally it attacks the bone and eats away body tissue. Yaws rarely kills. Instead, it leaves its victims to drag on in constant pain, permanently crippled. Since it usually starts in childhood, millions suffer for life.

Today, however, UNICEF is helping eight countries attack the disease. Among other essentials, the fund provides penicillin—just 15 cents worth of which is usually enough to cure. So far, UNICEF-aided campaigns have treated 3,000,000—more than 5 percent of the estimated cases in the world.

The appreciation of people who have been freed from the curse of yaws is boundless. Not long ago, tribesmen of an Indonesian village gave a feast in honor of penicillin and UNICEF. The newly cured villagers danced late to the music of the gamelon. Children happily stamped their feet—children who only a few weeks ago walked gingerly on their ulcerated soles and who now have a chance to grow into productive rather than dependent members of their community.

In other UNICEF-aided campaigns the target is tuberculosis. Asiatics call it the "quiet death" for it takes 5,000,000 lives every year.

One day last winter, in the remote mud and clay village of Sachakhera in India, a young mother named Muthiri gathered her children and followed a health worker to a spot where all of the youngsters of the village were lined up to be tested and, if they had no trace of tuberculosis, to be vaccinated with BCG vaccine.

On this day, the children of Sachakhera joined the 24,000,000 people in Asia, the eastern Mediterranean region, and Latin America who were tested in 1953 and the 50,000,000 who have been tested by UNICEF-equipped health teams since the fund began providing vaccine and other supplies to combat the disease. India's campaign—the largest antituberculosis campaign in the world—is only one of many which the fund is aiding. Today, in 33 countries, the summoning of the villagers to the vaccination post is often the first call to a better life chance for millions of youngsters.

In 35 countries, UNICEF is helping to initiate

A Thailand midwife weighs a week-old baby which she delivered. She received her training at a city Maternity and Child Welfare Center, equipped by UNICEF in 1951 as demonstration and training headquarters to serve a whole province. This midwife, in turn, trains other midwives.

This Indian girl has carried her baby brother to a public health clinic in a village in Guatemala. There the children receive a daily ration of milk, sent in powdered form by UNICEF. Some 200 undernourished children and mothers are served by the clinic, one of many UNICEF-aided clinics in Latin America.

A Brahmin health visitor checks the blood of an Indian child for malaria. UNICEF assistance, matched by the Indian Government, has already protected 16 million children through mass DDT sprayings. This year a government-constructed plant, equipped by UNICEF, will start producing DDT.

At a village clinic near Ankara, a father registers his child with a Turkish anti-TB team. The team will test the child for TB. If his reaction is negative, he will be immunized with BCG vaccine. UNICEF is helping Turkey carry out a 5-year campaign to reach 10 million children with vaccinations.

control of another disease—malaria, which takes 3,000,000 lives every year. Armed with UNICEF DDT, health teams have penetrated remote regions from Africa to Latin America to protect 12,000,000 people from the disease.

Ceylon was the first country in Asia to use UNICEF DDT against malaria. Four years ago one-tenth of the patients who jammed hospitals and dispensaries needed treatment for the disease. Two years later, partly due to the UNICEF-aided campaign, the number of cases was cut by two-thirds and the infant death rate from all causes had been halved.

In Latin America Dr. Oscar Vargas, Director General of Public Health, exhibits a chart showing the percentage of people admitted to Costa Rica's largest hospital with past or present malaria. Starting with a peak near 100 percent, the line drops precipitously to less than 10 percent after UNICEF and WHO joined the government in a campaign against the disease. The record for children is even more dramatic. It has dropped to zero.

"Children who have had malaria are an easy prey to other diseases," Dr. Vargas said. "Now they don't have it any more. UNICEF made that record possible."

Besides saving thousands of children from death or from handicaps which would warp their entire lives, these health-restoring activities are enabling people to work. In Haiti, for example, it is estimated that, for every 100,000 workers cured of yaws, the national annual income has risen $5,000,000.

Dr. J. A. Concha Venegas, Chief of the Malariology Section of the Ministry of Public Health in Colombia, recently presented further evidence that the cost of sickness is much higher than the cost of health. The annual cost of malaria in Colombia, he stated, is nearly twice the amount that a 4-year campaign for its control would entail. If $13,000,000 were spent on malaria control in 4 years, Dr. Concha Venegas estimates that $23,000,000 would be saved each succeeding year in such expenses as loss of work, deaths, and public assistance. The Government is now making a start, through an antimalaria campaign, to protect 1,600,000 people in the country. To do it, UNICEF is contributing $111,500—the Government almost five times this amount.

Besides carrying out extensive disease campaigns, many countries are establishing plants and laboratories for the production of antibiotics and vaccines which will enable them to continue and expand the

campaigns after UNICEF aid ends. UNICEF provides imported production equipment. The countries pay for the buildings and other local expenses.

Penicillin produced at the first UNICEF-equipped antibiotics plant to start operation will soon be shipped to health institutions throughout Yugoslavia to free thousands of children from pneumonia, scarlet fever, infant diarrhea, and endemic syphilis. Other plants, in Chile and India, will start up this year.

Eighteen countries are now making BCG vaccine in UNICEF-equipped laboratories. In others, combined diphtheria-whooping-cough vaccine is in production. Ceylon, India, Pakistan, and Egypt will soon continue UNICEF-aided campaigns against malaria with DDT produced locally at plants equipped by the fund.

Besides increasing the supply of antibiotics and vaccines, these plants serve as training centers for technicians both from within and outside of the country. Frequently, too, they are able to manufacture enough not only to meet the needs of their own children but those of other countries as well.

Just a little over a year ago, for example, the first batch of antituberculosis BCG vaccine ever made in Ecuador was produced at a laboratory on the grounds of the National Institute of Hygiene in Guayaquil. Up to this time, vaccine had been supplied to Ecuador by air from a UNICEF-equipped production laboratory in Mexico, also the source of vaccine for antituberculosis campaigns in seven other Latin American countries. Now Ecuador, in turn, produces enough vaccine each month to supply her own tuberculosis-control services and to export to nearby countries as well.

UNICEF provided $75,000 worth of supplies and equipment for training and research in the Ecuador program. Ecuador's investment was twice this—$150,000 for buildings, facilities for highly specialized laboratories, and operating expenses for the first year alone.

UNICEF was established after World War II chiefly to provide emergency relief for European children suffering from the years of hostilities. At that time, the fund's principal weapon was powdered skim milk. About 1950, with recovery in Europe, UNICEF turned its attention to needier children in the world's underdeveloped regions with a view to helping governments set up health projects to benefit children over a long period of time. In this long-range effort, powdered skim milk, a large part of which has been purchased from United States Government surplus stocks, still plays a significant role.

In El Salvador, for example, UNICEF milk has exerted a far-reaching influence on the health of children and on the economy of the country as well.

Most children in this small Central American republic have suffered from malnutrition for generations. In 1949 the majority of those able to get to school at all arrived hungry and apathetic, and 1 out of 3 reporting to clinics suffered acute hunger sickness. The Government, aware of this, had started lunch programs in three schools, and then asked UNICEF to supply dried skim milk for a major feeding demonstration.

The first milk arrived in April 1950. Within 2 months, 32,000 children were happily drinking it, and teachers began reporting that their once-apathetic pupils were wide-awake and learned much more quickly.

At this point the Government found itself in the center of a ferment. Parents and teachers, aroused to the effects of nutrition, demanded to know more. Mayors of communities not participating in the demonstration clamored to get UNICEF milk in their municipalities. In the entire country there had been just two clinics for infant nutrition. By June 1950, 14 community clinics were operating and 26 more preparing to open. Farmers saw the growing interest in milk and wondered if they couldn't expand, too.

Dr. Juan Allwood Paredes, Director General of Public Health for El Salvador, said: "UNICEF milk became the focal point in alleviating our chronic emergency. The wide interest it aroused enabled us greatly to broaden our education system, our public health programs and our nutrition education. Inevitably, through increased dairying and related industries, it will vitally affect our economy."

National, municipal, and private expenditures in El Salvador during the 18 months after April 1950 totaled $276,744. UNICEF spent only about one-fifth that amount—$52,400—for the milk which supplied the missing yet essential part of the program. Today, it seems inconceivable that the country's children will ever again go without milk.

To date, including El Salvador's children, 11,500,000 youngsters and nursing and expectant mothers have received cups of UNICEF milk. In Latin American countries it is integrated with government-sponsored school-lunch programs. In Latin

America, Asia, and the Middle East, children and mothers at maternal and child welfare centers get daily cups of the protein-rich food. In Africa, UNICEF milk is helping to combat a serious protein deficiency disease.

The disease is known locally as "kwashiorkor," meaning "red boy," for the inhabitant say that it turns skin and hair red. Children from 2 to 5 years old are the principal victims of the disease which not only weakens but often kills. Caught in its early stages, however, kwashiorkor clears up rapidly. To help prevent it, UNICEF is now sending barrels of skim milk powder along the footpaths of the Belgian Congo, the Trust Territory of Ruanda Urundi, and French Equatorial Africa. With this aid, some 340,000 children and mothers will be protected.

Although most of its assistance goes into long-term projects, UNICEF still lends a helping hand to mothers and children in regions afflicted in emergencies. Today, in the earthquake-stricken Ionian Islands of Greece, in famine and flood-ridden areas of India and Japan, and in the Republic of Korea, UNICEF milk, sometimes fish-liver oil, soap, blankets, wool for clothing, and drugs are helping to relieve widespread misery.

But UNICEF milk has done more than nourish millions of sickly children. It has bred popular interest in good nutrition, caused expansion of local private dairy industries, and stimulated governments of many countries to construct drying, pasteurizing, or sterilizing plants to conserve supplies of safe milk.

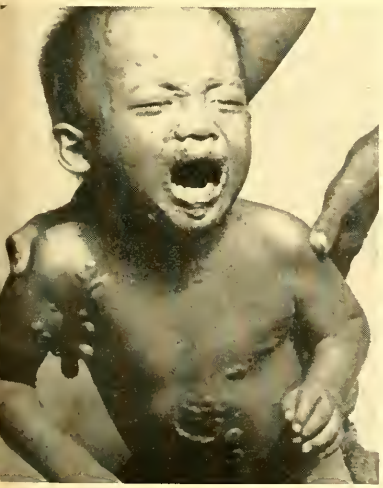
In Nicaragua, for example, milk producers organized a cooperative and built a modern pasteurizing plant when interest in milk was aroused by the dramatic improvement in the health of some 40,000 school children who participated in a UNICEF-aided milk-feeding program.

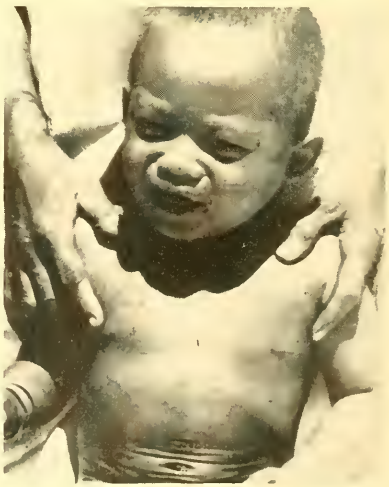
In northeastern Brazil, two new dealers began importing commercial milk while UNICEF was supplying large quantities to children in the drought-stricken areas.

In 23 countries, UNICEF-aided milk plants are under construction, in some cases already in operation. Through modern processing methods, precious supplies of milk, most of which have been wasted in the past, will be conserved. UNICEF contributes imported processing equipment such as drying and pasteurizing units. Governments are matching $8,000,000 in UNICEF assistance about 5 to 1 to build the plants and will spend an additional $100,000,000 to provide free milk for about 3,300,000 children after all the plants start production.

Nearly 2,000,000 children are already getting daily free cups of milk from UNICEF-aided plants. In Malta, where undulant fever struck hundreds of children each year before UNICEF supplied pasteurizing equipment for the country's only dairy plant, 11,000 youngsters get free pasteurized milk every day and the disease has been almost completely wiped out.

In Chile, the problem of transportation in a long, narrow country had hampered the development of





Seven cents worth of penicillin accomplished this transformation in a little Indonesian boy who was photographed 2 weeks before and 2 weeks after an injection of penicillin for yaws. With the help of UNICEF supplies and WHO technical advice, Indonesia is waging a campaign to wipe out yaws. So far almost 1 million persons — two-thirds of them mothers and children—have been cured

an excellent dairy industry, and most children had been unable to get milk. The solution, Chile and UNICEF milk conservation experts agreed, lay in drying seasonal surpluses, for dried milk keeps for months and is easy to transport. UNICEF shipped drying equipment for a plant which is just beginning to operate. When it goes into full production, the milk powder will be given by the Government to undernourished children—approximately 90,000.

In nondairy countries, the Food and Agriculture Organization is helping to develop milk substitutes to fill the need for a nutritious, easily digestible food for children. Indonesia, with FAO aid, has developed a "vegetable milk" composed of protein-rich soybeans, peanuts, and malt, and UNICEF is now helping to equip a plant near Jogjakarta to produce it. When the plant starts operating, the Government will give free cups of the "vegetable milk" to some 13,500 children and mothers to balance their traditional polished rice diet.

The children of Indonesia need this "milk." Other millions also need help. Two-thirds of the world's children lack food, clothing, shelter, and protection against disease. They can look forward only to short lives burdened by disease, hunger, and privation.

On recent trips to Asia, the Middle East, and Africa, what struck me most forcefully was the fact that disease among children in these regions today constitutes a greater emergency than among children in the devastated areas of Europe after the war. What next impressed me were the tremendous strides taken in the past 4 years to meet this situation. Although a great deal remains to be done, a significant start, the most ambitious one ever attempted by man, has been made. UNICEF, FAO, WHO, and other United Nations agencies are pointing the way by supplying equipment and technical guidance. Governments, realizing that they can't afford to *cure* sickness, are exerting every effort to *prevent* it.

As countries grow stronger, healthier, and more productive, they will be able to earmark more funds for the improvement of health, particularly the health of children on whom the world's future depends. UNICEF's resources come entirely from the voluntary contributions of governments and private organizations and individuals. The United States has been the largest single contributor, although on a per capita basis several countries have contributed more. During the past 4 years, the number of contributing governments and the sums contributed have steadily risen. As long as they are made, UNICEF will continue to provide a powerful stimulus toward bettering the health of the world's sick children.

As the public health head of one Latin American republic put it: "We thought a campaign to wipe out malaria was utterly beyond us. UNICEF stepped up with a few thousand dollars in DDT and spraying equipment, the World Health Organization offered some technical advice, and, the first thing you know, we had malaria licked. Now we could take on any kind of campaign. It taught us confidence in our own ability."

Statistics proving the value of UNICEF aid don't tell the story. Illustrations like the following do:

Deep in the drought area of northeastern Brazil, the priest of the village of Pacoti listened while a visitor from UNICEF asked what UNICEF milk powder and equipment for local health services had done for the mothers and children of this remote village.

In answer, the priest pointed to his church steeple. "It used to toll the death of a baby 3 or 4 times a week," he said. "Now it tolls only 3 or 4 times a month."

CHAMPION OF CHILDREN

The National Child Labor Committee celebrates its 50th anniversary in April 1954. The Committee works to eliminate harmful employment for children and youth and to promote educational opportunities for them.

In 1904, when the Committee began its work, child labor in coal mines, cotton mills, and canneries was common. Many children, even young ones, worked long hours, at night, and at hazardous jobs; and they had little chance to go to school.

Today such employment is rare. But in commercial agriculture, for example, especially among migrant families, large numbers of children work under conditions detrimental to their well-being. The National Child Labor Committee is working with public and private groups and with individuals to better the lot of these children.

A WORLD VIEW OF SOCIAL WORK

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AS A THRILLING and challenging call to social workers in all parts of the world to exercise leadership in the formulation of broad social policy and to participate in its effectuation—particularly as related to improvement of standards of living everywhere—The Proceedings of the Sixth International Conference of Social Work [1] deserve a wide reading. For those fortunate enough to have attended the Madras meeting, the volume will be a treasured souvenir of what was universally agreed to have been an "experience of a lifetime."

For those who were unable themselves to attend the Madras Conference, the Proceedings will be found colorfully, movingly, and convincingly to communicate the essence of the informing and challenging papers and discussions; the warmth of India's hospitality to the 1,200 conferees from 35 countries and 20 international agencies and of the friendliness of their own relationships one with another; the importance attached to the Conference by Indian and other Asian leaders whose messages to the Conference and services in its behalf amply attested their conviction about the significance of this first meeting of the International Conference in Asia. Readers will even learn what is a "Shamiana" and will see a picture of one—a picture which will undoubtedly recall to attendants at the Conference one of the most colorful and delightful memories of their professional lives.

Assuming that readers of CHILDREN will be interested primarily in what emphasis the Conference, concerned with social service and standards of living, placed upon children and youth, the answer can be simply stated: In discussions of even the most general subjects, children were never out of mind. In discussions focusing specifically upon children and youth, the broader and inescapable issues of their families, general standards of nutrition and productivity, and the respective roles of governmental and voluntary agency responsibilities were never lost from view.

For example, when the Conference's beloved honorary president, Dr. René Sand of Belgium (whose death has recently been announced) enumerated the concerns of earlier conferences he alluded in particular to "Mothers and Child Welfare." Similarly, the United States then-Ambassador Chester Bowles, in a mind-stretching and spirit-expanding address, repeatedly referred to children and to education in his own and other countries; at one point, he declared that in the next few years in India, "Tens of millions of mothers and fathers will be seeking new guidance in the development of their family life, in the solving of the many problems that lie all around them." Had social workers of the world no other work to do, here indeed is a challenge worthy of their collective mettle.

The United States' own Lester Granger—whom we can no longer claim for ourselves alone since he has now assumed a prominent place of world leadership social-work-wise—also underlined the points in his address on "Basic Human Needs" by referring to such tragic facts as that "one-half of the children of some Asian countries" die before their sixth year and that "China's infant mortality rate is 4 times that of Great Britain."

Whether it was Dr. J. F. Bulsara (United Nations) discussing the role of social service in "Raising the Standards of Living," Mlle. A. Vicat (France) describing the "Most Significant Aspects of the Work and Equipment of the Social Worker and the Public Health Worker," Mr. Rif' at Habbab (United Nations) telling of "Social Life Among the Arab Palestinian Refugees," Miss Eileen Davidson (United Nations) picturing "Maternal and Child Health Centers in Thailand," Dr. Alva Myrdal (United Nations) analyzing the subject "Education and the Standards of Living," one could hardly forget—even if he wanted to—that children and youth, though perhaps not specifically mentioned, were cardinal reasons for these various discussions of education, family life, nutrition, health, social work, and the raising of standards of living in the world. Moreover, the Conference's central concern was clearly something that would take time to effect if anything like the degree of improvement envisaged by the Conference was to be achieved. Equally clearly, this success could not be expected to be achieved during the lifetime of adults now living. Thus, the real beneficiaries of the Conference may be said to be not

the parents but the children of the world, their children, and theirs.

Two of the 10 discussion groups into which the Conference was divided to permit more intimate and detailed discussion of particular interests dealt specifically with "Services to Children and Youth," and "Services for Family Life." It is notable that these groups (as indeed *any* groups concerned with these subjects must do) found themselves inevitably wrestling not with problems relating only to children but with problems affecting community development, the philosophy of governmental as contrasted with voluntary action, personnel shortages, professional training, the importance of voluntary service, and social action.

The Conference's emphasis upon social action and the prime importance of social work participation in the formulation of social policy may well have been one of the Conference's most constructive reminders that social work is not merely ameliorative. In fact, Commission II which, under the chairmanship of Miss Eileen Younghusband (United Kingdom), discussed the "Application of Social Work Skills and Techniques to the Problem of Underdeveloped Areas" explicitly agreed that "Social work is designed to make it possible for the individual to achieve his maximum potential through existing institutions or to *modify* existing institutions to provide a *healthier environment* (*physical, emotional, social,* and *spiritual*) in which the individuals may grow and function to the fullest of tneir individual capacities." [Italics not in the original.]

The Proceedings of the Sixth International Conference of Social Work clearly reveal that, welfare-wise, the world is indeed one world; its needs indivisible. They also reveal that when social workers, though they come from 35 countries, seriously discuss what can best be done to meet these indivisible needs of their one world they find themselves to a remarkable degree—so far as fundamentals are concerned—to be of one mind and to be motivated by a singleness of purpose. Social workers of the world, therefore, will long be indebted not only to the original writers of the papers presented and to participants in the Conference's commissions and discussion groups but also to the editors of the Proceedings: Miss Shirin F. Dastur, and Mrs. Gulestan R. B. Billimoria (India) whom many American readers undoubtedly met when she was in the United States just prior to the Madras meeting. To genial Mr. B. Chatterjee (India) who is similarly remembered with warm appreciation from California to New York, readers are indebted for the dispatch with which the Proceedings were published.

One nationally known social worker from the United States, for whom the Madras Conference was the first such meeting ever attended, later said that this was one of the most "shaking" experiences of his professional life. He also said that had he attended such a conference some 20 years earlier he would have avoided many mistakes made during his professional career.

American readers of the Proceedings who have never attended an International Conference of Social Work and who desire to spare themselves the possibility of similar remorse 20 years hence may be glad to recall that the Seventh International Conference is being held in readily accessible Toronto, June 27 to July 3, 1954.

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[1] Social Service and the Standards of Living; Proceedings of the Sixth International Conference of Social Work, Madras, India, 1952. 305 pp.+XII, Appendices. Published by the South-East Asia Regional Office, International Conference of Social Work, Bombay, India. (Headquarters Office, 22 West Gay Street, Columbus, Ohio, U. S. A.)

BOOK NOTES

HEALTH SERVICES FOR THE CHILD. Edward R. Schlesinger, M. D., M. P. H. McGraw-Hill, New York. 1953. 403 pp. $7.50.

The author states that the purpose of the book is to give an integrated picture of health services for mothers and children. The book covers in detail the background, planning, administration and evaluation of the child health program, the types of essential health services, health supervision of mother and child, and services to children with special problems.

Dr. Schlesinger was formerly the Director of Maternal and Child Health Services of the New York State Health Department and at present is the Associate Director of Medical Services of the same department.

UNDERSTANDING BOYS. Clarence G. Moser. Association Press, New York. 1953. 190 pp. $2.50.

"Written by one whose years of intimate leadership of boys shared with the boys themselves, with parents, other adults, and communities, has

built a faith in the ability and desire of all of them to play their part in the boy's development."

Professional workers should not be deceived into thinking that the popular style of Mr. Moser's book means that it is for lay readers only.

AGGRESSION, HOSTILITY AND ANXIETY IN CHILDREN. Lauretta Bender, M. D. C. C. Thomas, Springfield, Ill. 1953. 184 pp. $5.50.

In a second book of a series of Bellevue Studies of Child Psychiatry, Dr. Bender has unified and rewritten a collection of previously published papers by five members of the Bellevue staff. The chapters discuss children's attitudes toward death, preoccupation with suicide, homicidal aggression, firesetting, the genesis of hostility in children, and anxiety in disturbed children.

Over 50 of the 260 children and young adolescents originally studied and reported on between 1934 and 1940 were subjects of followup investigations in 1950 and 1951. The resulting data from their late adolescence or early adulthood are included in the papers.

A COURT FOR CHILDREN: A Study of the New York City Children's Court. Alfred J. Kahn. Columbia University Press, New York. 1953. 359 pp. $4.50.

A report on the operation of the country's largest and most complex juvenile court. Based on extensive direct observation and study, the report covers the structure of the court and the work of its various departments—intake, judiciary, probation, clinic, etc.—pointing out strengths anad weaknesses. Concludes with recommendations for changes and new development.

THE JUVENILE OFFENDER. Clyde B. Vedder, Ph. D. Doubleday, New York. 1954. 510 pp. $6.

This book brings together in one volume numerous authoritative writings on the subject of juvenile delinquency that have appeared in various professional journals. The readings are arranged in chapters that reflect the principal divisions of the field of juvenile delinquency, and each chapter is introduced by a brief textual discussion written to serve as a guide to the reader. The author believes the book will be especially useful for teachers and their students.

A FOLLOW-UP STUDY OF THE RESULTS OF SOCIAL CASEWORK. Leonard S. Kogan, Ph. D., J. McVicker Hunt, Ph. D. and Phyllis F. Bartelme, Ph. D. Family Service Association of America, New York. 1953. 115 pp. $2.50.

This is a report of a study conducted by the Community Service Society of New York. The study attempted to find out about the effects of family casework services five years after the cases were closed. The method used involved interviews with ex-clients by an experienced clinical psychologist completely unfamiliar with the development or outcome of the cases.

The report, presented in a rather technical fashion, is interesting for its development of research methodology, as well as for its findings.

FATHER RELATIONS OF WAR-BORN CHILDREN. Lois Meek Stolz, Ph. D., et al. Stanford University Press, Stanford, California. 1954. 365 pp. $4.

"The study is a direct outgrowth of the social concern for the effect of war on the mental health of children which was prevalent during the 1940–50 decade."

Made possible by a grant from the National Institute of Mental Health of the United States Public Health Service, the investigation undertook to analyze the adjustments of father and first-born child to the stress brought about by the father's return after absence in war service lasting from before the birth of the child until the child was over a year old.

GUIDE TO THE OPERATION OF GROUP DAY CARE PROGRAMS. Child Welfare League of America. The League, New York. 1953. 70 pp. $1.

A comprehensive statement of standards for day care centers, developed by the National Day Care Committee of the League. The meaning of day care, the responsibilities of the operating body, the needed plant and equipment, the staff and the program for different age groups are simply and clearly described. The educational backgrounds of the teacher and of the caseworker in a day care center are spelled out in some detail, and a useful bibliography is included.

PROBLEMS OF INFANCY AND CHILDHOOD: Transactions of the Sixth Conference. Milton J. E. Senn, M. D., ed. Josiah Macy, Jr. Foundation. New York. 1953. 160 pp. $2.50.

Contents of this volume include papers on Emotional Development in the First Year of Life, by Dr. Sibylle Escalona of the Child Study Center at Yale University, A Brief Review of WHO Activities, by Knut Kjellberg of the Maternal and Child Health Division of WHO in Geneva, Observation of Individual Tendencies in the First Year of Life, by Dr. Katherine M. Wolf, Child Study Center, Yale University, and Excessive Crying in Infants—A Family Disease, by Dr. Ann Stewart of the University of Washington.

THE CHILD, HIS PARENTS AND THE NURSE. Florence G. Blake, R. N., M. A. Lippincott, Philadelphia. 1954. 440 pp. $5.

In this text the author, who is Associate Professor of Nursing Education, University of Chicago, brings together the results of her years of study and experience in developing an advanced course for graduate nurses in the nursing care of children. It contains a foreword by Dr. Adrian H. VanderVeer, under whom Miss Blake took a 3-year course in psychoanalytic child care.

FILMS, IN PSYCHIATRY, PSYCHOLOGY AND MENTAL HEALTH. Adolf Nichtenhauser, M. D., Marie L. Coleman and David S. Ruhe, M. D. Health Education Council, New York. 1953. 269 pp. $6.

The detailed critical reviews of 51 films and brief descriptions of 50 others that comprise the main part of this book will, its authors hope, make films in psychiatry, psychology and mental health "more useful to more people." Some of

the films are for use in professional teaching only, others for use with the general public. The end papers of the book serve as charts that make clear the audiences with which the films can appropriately be used.

The Medical Audio-Visual Institute of the Association of American Medical Colleges has prepared this volume in recognition of the need for "reliable descriptive and evaluative information" on films. The list includes films available up to January 1953.

STUDY OF THE BASIC STRUCTURE FOR CHILDREN'S SERVICES IN MICHIGAN. Maxine Boord Virtue. The American Judicature Society for the James Foster Foundation, Ann Arbor. 1953. $5.

"The first work to treat of children, even in a single State, in the entirety of their relation to the law instead of piecemeal in relation to individual agencies . . ." The book compares the Michigan practice with experience elsewhere in the United States and in Europe.

PSYCHOLOGICAL PROBLEMS IN MENTAL DEFICIENCY. Seymour B. Sarason, Ph. D. Harper, New York. 2d Ed. 1953. 402 pp. $5.

The first edition of this book, published in 1949, provided a detailed evaluation of diagnostic criteria and etiological classifications in the field of mental deficiency, with a brief consideration of some of the practical problems involved in working with mental defectives. In the second edition Dr. Sarason has added three chapters on interpretation of mental deficiency to parents, the problems of institutionalization, and some of the problems of professional training. Formerly the Chief Psychologist of the Southbury Training School in Connecticut, Dr. Sarason is now Associate Professor of Psychology at Yale University.

CHILD TRAINING AND PERSONALITY. John W. M. Whiting, Ph. D., and Irvin L. Child, Ph. D. Yale University Press, New Haven. 1953. 353 pp. $5.

This is an analysis of child rearing practices in 75 different cultures, including the American middle class culture. The purpose of the analysis is to attempt to clarify the basic and perennial question of the relationship between certain kinds of experiences in infancy and adult personality and behavior. Concepts derived from psychoanalytic and social learning theory are used in developing integrating and explanatory hypotheses. Problems in personality development, around which these hypotheses center, are the fixation of behavior patterns, the origins of guilt, and the origins of unrealistic fears of other persons. An attempt is made to explain individual differences in personality among members of Western societies.

Of special interest to workers in child health and welfare is the analysis of practices relating to illness and the significance of these practices for personality development.

TWINS: A Study of Three Pairs of Identical Twins. Dorothy Burlingham, Ph. D. International Universities Press, New York. 1953. 94 pp. $7.50.

In this book, which is based on observations in the Hampstead Nurseries, 1940–45, the behavior of two pairs of girl twins and one pair of boy twins is described, with chapters on the beginning of the twin relationship, twins as a team, the overcoming of jealousy, the effect of separation, and the relationship of the twins to their parents.

Thirty charts showing minute details of behavior over periods of some months (such as temperamental differences in the feeding situation) offer readers, especially parents of twins, additional glimpses into a little-explored country.

CHILD DEVELOPMENT: the Process of Growing Up in Society. William E. Martin, Ph. D., and Celia Burns Stendler, Ph. D. Harcourt, Brace, New York. 1953. 519 pp. $6.50.

This book takes a fresh approach to its topic: it is oriented around the analysis of the sociocultural factors which influence the development of children.

By weaving in materials from anthropological and sociological studies with data from child development studies, the authors present a more integrated picture of the growth of the child in our culture than is found in the usual textbook in child development.

The authors start with the basic premise that "the process of development is a social process." Among the questions which are considered are: "In what ways is the process of growth and development similar for all children, regardless of the particular society in which they are born and reared? What differences among children can be ascribed to biological inheritance rather than to the influence of society? What is the relationship between the society with its culture and the personality we find in the members of that society?"

The final section considers the role of parents, teachers, the peer culture, and the community at large in the socialization of the child.

THESE ARE YOUR CHILDREN. A Text and Guide on Child Development. Gladys Gardner Jenkins, Helen Shacter, Ph. D., and William W. Bauer, M. D. Scott, Foresman, Chicago. Expanded Edition. 1953. 320 pp. $4.75.

The textual content of this manual, in whose earlier edition photographs carried an unusually large share of the job of informing the reader, has been considerably added to in the new edition. Directed to all who want to understand children better, whether at home, in school, or in the community, the book emphasizes the continuous nature of growth, and the importance of the early years. An extensive bibliography is included.

ANALYZING AND PREDICTING JUVENILE DELINQUENCY WITH THE MMPI. Starke R. Hathaway, Ph. D. and Elio D. Monachesi, Ph. D., eds. University of Minnesota Press, Minneapolis. 1953. 153 pp. $3.50.

This reports several studies on the value of the Minnesota Multiphasic Personality Inventory for predicting delinquency. In the main study (pp. 87–135) over 4,000 children were given the inventory while in the ninth grade and were followed for 2 years, during which time 591 came before local courts or police. The combinations of scores which best discriminated the 591 children are set forth in detail. While believing that even more distinctive score patterns could and should be derived with further work, the authors hold that the results obtained so far have "immediate practical value" for predicting delinquency.

SOME U. S. GOVERNMENT PUBLICATIONS FOR PROFESSIONAL WORKERS

Publications for which prices are quoted are for sale by the Superintendent of Documents, United States Government Printing Office, Washington 25, D. C. Orders should be accompanied by cash, check, or money order.

DIRECTORY OF FULL-TIME LOCAL HEALTH UNITS, 1953. U. S. Department of Health, Education, and Welfare, Public Health Service. Publication No. 118. 1953. 58 pp. 20 cents. Processed. Single copies available from the Public Health Service without charge.

This directory, revised as of July 1953, presents a listing of full-time health units serving local areas, together with the name of the health officer of each unit or other designated administrative head. The information is compiled from data reported to the Public Health Service by full-time local health units and State health officers. One of the two appendixes summarizes the number of full-time units in each State in which the position of health officer is vacant.

HEALTH MANPOWER SOURCE BOOK. Department of Health, Education, and Welfare, Public Health Service. Publication 263. Three sections of a projected series on the number, distribution, and characteristics of members of about 18 selected health occupations. Processed. Single copies of each of these three sections available from the Public Health Service without charge.

Section 1, preliminary, by Maryland Y. Pennell and Marion E. Altenderfer, is on physicians. The Public Health Service invites suggestions on this section so that the final publication may be a further refinement and expansion of the data (May 1952. 70 pp. 40 cents). Section 2, by Helen G. Tibbitts and Eugene Levine, is on nursing personnel (May 1953. 88 pp. 40 cents). Section 3, by Leslie W. Knott, M. D., M. P. H.; Lucille M. Smith, and Ruth Wadman, is on medical social workers (August 1953. 78 pp. 40 cents).

PLANNING SERVICES FOR CHILDREN OF EMPLOYED MOTHERS; a report prepared by a subcommittee of the Interdepartmental Committee on Children and Youth. U. S. Department of Labor, Women's Bureau. 1953. 62 pp. 20 cents. Single copies available from the Children's Bureau without charge.

Summarizes the recent experience of Federal agencies in providing advisory service and administering funds for certain types of child-care and educational programs including children of employed mothers. It analyzes State enabling legislation for improving school programs for young children and for the protection of children under care outside their own homes.

Federal agencies represented on the subcommittee were the Children's Bureau, the Bureau of Public Assistance, and the Office of Education, of the Department of Health, Education, and Welfare; and the Bureau of Employment Security and the Women's Bureau, of the Department of Labor.

THE BOY BEHIND THE PINS; a report on pinsetters in bowling alleys. United States Department of Labor, Bureau of Labor Standards. Bull. 170. 1953. 47 pp. 25 cents. Single copies available from the Bureau of Labor Standards without charge.

Bowling means sport to the players, but trouble for labor-department and school officials. This report of a survey made by the Bureau of Labor Standards explains why. It discusses the conditions under which pinboys in bowling alleys work and the problems of labor supply that harass the proprietors. Recommendations for improving the labor conditions and for helping the proprietors meet their problems are included. The bulletin also suggests ways in which people concerned can work to put these recommendations into effect.

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OFFICIAL BUSINESS

A PROFESSIONAL JOURNAL ON SERVICES FOR CHILDREN AND ON CHILD LIFE

U. S. DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
Oveta Culp Hobby, *Secretary*

SOCIAL SECURITY ADMINISTRATION
John W. Tramburg, *Commissioner*

CHILDREN'S BUREAU
Martha M. Eliot, M. D., *Chief*

MAY · JUNE 1954

children

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VOLUME I

NUMBER 3

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(*formerly* THE CHILD)

It is a rare State in the Union that has no children of migrant farm families, but Florida's quota is particularly complex. Though the problems are interstate in character, Florida is showing that it can, on its own, make some headway with them, as is shown in Dorothea Andrews' article, MOPPETS WHO MIGRATE. Miss Andrews rounded off 6 years of reporting on health and welfare matters for the *Washington Post* before serving, for 3 years, as Press Officer for the Children's Bureau. She is now a free-lance writer.

How teamwork can speed up progress in dealing with a difficult problem in child health is the theme of Dr. Bechtol's article on prostheses for amputees. A member of the Upper and Lower Extremity Technical Committees of the Advisory Committee on Artificial Limbs, Dr. Bechtol is also Western Area Consultant to the Veterans Administration for orthopedic and prosthetic clinics, and Director of the physicians' program for the upper extremities.

One of the very few medical social workers in the Nation engaged full time in child health clinic work, Theresa Harder has behind her 14 years of professional service, divided almost equally between hospital and public health medical social work. In 1947, when she joined the District of Columbia Department of Health, she worked first in the Crippled Children's unit. More recently she has worked exclusively in child health clinics.

Our two reviewers of the new *Standards* for juvenile courts each has had close working relations with the other's profession. Professor Bradway, in addition to teaching law and directing the Legal Aid Clinic at Duke University, is a visiting professor at the University of North Carolina School of Social Work. He has pioneered in developing for law students clinical preparation for practice such as medical students get.

Before Mr. Anderson took his present position in 1953, he served for 6 years as Director of the Family Court for Newcastle County in Delaware where he was chief of probation services. Mr. Anderson was associated with the Cambridge-Somerville Youth Study (1938–41) made in 2 industrial cities in Massachusetts to test the effectiveness of special counseling and aid to "predelinquents."

Accident prevention has been an absorbing interest of Dr. Press for over 10 years. A member of the Accident Prevention Committee of the American Academy of Pediatrics, he also is Vice Chairman of the Health and Medical Division of the Home Safety Conference of the National Safety Council, and Chairman of the Chicago program described in his article.

All three physicians who author the article on San Francisco's Community-School Health Education Project have behind them wide experience in public health work. Dr. Singer-Brooks, who was on loan from the State Department of Public Health for the duration of the project, had been active in research before entering public health work in Sacramento, in 1950. Dr. Van der Slice's experience in school health programs covered a number of cities in Michigan before he joined the California State Department of Health in 1948. He went from the State to his Oakland position in 1950. Dr. Barrett was appointed Director of the San Francisco Bureau of Child Hygiene in 1931.

frontispiece

CHILD HEALTH AND WELFARE AGENCIES that struggle with the problem of how, photographically, to tell a story but do no injury to the recipients of service will find in this exquisite photograph of a child grasping a finger of his father's hand an illustration of photographic resourcefulness. This photograph, by Arthur C. Allen, was generously furnished by the Illinois Children's Home and Aid Society.

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READERS' EXCHANGE

GALLAGHER: "Both sitting on Mark Hopkins' log"

The comments of my good friend, President Gallagher ("The False Dichotomy of Professional *versus* General Education," CHILDREN, Vol. I, No. 2, pp. 46–49), have left me in this dreamlike daze that so often follows a rousing *non sequitur*. After a mental "double take," I am forced to conclude that we are speaking a different language.

Far from being the spokesman for "the case for the substantial elimination of liberal and general education in favor of professional competence," I have maintained during all of my professional life that studies in the social sciences and the humanities are an essential part of "professional competence" as opposed to mere technical proficiency.

A sociologist myself, my wide advocacy of this ideal brought my appointment as the first Dean of Humanities at the Massachusetts Institute of Technology in 1937. Under my administration at The Cooper Union, the curricula in art and engineering introduced liberal arts studies in an amount up to a fifth of the class hours required for graduation. And I have just been named chairman of an Advisory Committee for a comprehensive investigation of engineering colleges launched by the American Society for Engineering Education under a grant from the Carnegie Corporation, which has as its purpose the improvement of courses and teaching methods of socio-humanistic studies.

After long years of such activities, it comes as a shock to be accused of trying to resolve the problem of professional versus liberal education "by eliminating one or the other, or by separating one from the other." President Gallagher's "unstated conclusion" has been reached by a record-breaking broad jump that is the more spectacular since it was made backwards and blindfolded.

It is true that I argued that higher education, under present practices, was pricing itself out of the market and I suggested that one solution might be to give more education in less time. Here are . . . pertinent paragraphs from my report that led to President Gallagher's amazing paper:

"The colleges must reduce their cost by giving more education in less time, and by instilling in every student a passionate desire for filling in the gaps in his education through post-college study . . .

"Rising costs, combined with a little realized and less understood change in the social order, must of necessity bring about an acceptance of a less expensive and shorter educational base.

"If our educational structure were more flexible, I would urge . . . that the junior high school and the first 2 years of high school be combined into a "middle school" and the last 2 years of the present high school program be tightened up scholastically to the academic calibre of the European gymnasium or lycee.

"These new senior high schools would have two objectives. One type would . . . have a pronounced vocational content in order to equip its graduates to enter business, trades, and the arts. The other type would serve probably about two million youths who through self-imposed screening have demonstrated to themselves their intellectual promise for education and training for the professions. Since such a fundamental reorganization seems remote, the next most intelligent development would be to ascribe more acceptability to the junior college and to establish the desirability of the 2-year degree of 'associate' in arts or science for all except those entering the most exacting professions."

When President Gallagher proposes to meet me on my own ground, he will find that he need not travel far, since we are both sitting on Mark Hopkins' log . . .

> Men are never so likely to settle a question rightly as when they discuss it freely.
> T. B. Macaulay: *Southey's Colloquies* 1830

If President Gallagher is setting up a pageant for his crusade to establish a world series tilt at the windmill of educational antinomianism, I must refuse the role of the archvillain, Sir Mordred. Type casting, I feel, should put me in the shining armor of Sir Galahad.

Edwin S. Burdell, President, The Cooper Union for the Advancement of Science and Art

I am very pleased that President Burdell—whom I count not only as a good friend but also as one of the ablest of educational administrators—has been given an opportunity to recast himself in an appropriate role as this material goes to press.

I accept completely his correction of his intended meaning, and regret that either his ellipses of phrase or my own intellectual obtusity prevented me from seeing through his language to his real intentions. I am content to let Burdell disclaim the characterization as a straw man, for I was not aiming my darts at him as an individual. I take it that he and I stand together in common opposition to the position which I had attributed to him—and I thank him for his good natured willingness to let the accusation stand, provided it applies to a position which he disavows.

Buell G. Gallagher, President The City College, New York.

MAURICE PATE "Inspiring saga"

The story of UNICEF's tremendous work in combating disease, hunger and ignorance among the world's needy children without regard to color, creed or nationality, is one of the most inspiring sagas of modern times. The article by Maurice Pate, Executive Director of the United Nations Children's Fund (UNICEF) which appears in the March–April issue of CHILDREN (pp. 70–76) is a message which every American should read and be proud of . . . UNICEF has proved that the United Nations is a truly effective means of building a better world. Mr. Pate shows that this world organization means not only formal debate but a forceful and direct attack upon the practical problems oppressing mankind.

More than 70,000,000 children have received assistance from UNICEF, but

there are still more than 500,000,000 children living in areas where health and welfare services are inadequate, disease and hunger rampant. The United States shares with the world a responsibility to continue to provide UNICEF's services—the best support for the future peace and happiness of the world's people.

Helenka (Mrs. Guido) Pantaleoni
Chairman, U. S. Committee
for UNICEF

DYBWAD: "All kinds of parents"

As a person with experience with parents' groups, I have read with mixed feelings Gunnar Dybwad's article ("Leadership in Parent Education," CHILDREN, Vol. I, No. 1, pp. 10–14). While I admired his carefully documented approach, I felt some disappointment in his failure to deal explicitly with parents as persons.

There are all kinds of parents, and all varieties of parents' groups. In my experience, it is imperative to recognize the tremendous variations among parents, in background, in readiness, in definition of the situation, in degree of involvement, and in the motivation that brings them to parents' groups.

Consider, for instance, the difference to be found between a group of mothers of very young children concerned with toilet training, food habits, and the other elementals of early parent-child interaction, and the interests of a group of parents of adolescents facing the threats and strains of parent-adolescent conflict.

Or, take as other simple examples of group variation, the small group of second generation city mothers who meet in a neighborhood house, the sophisticated urbane men and women who attend parents' sessions in a downtown office building, and the farm women who come for a series of meetings on child development under the auspices of the extension department or the county health program.

The unique orientation of each group, and ultimately each person, must be recognized and used insightfully by the leader if a dynamic educational process is to be established. Just because the groups are made up of parents is not definitive enough to be helpful to the sensitive educator.

One of our problems lies in the very approach we take to parents. As long as we see them as the way in which we can influence their children, we play a kind of mental leap-frog with them. We touch them, true, but only so we may reach their children. It is only when we become interested in parents as persons that we can hope to meet their needs effectively.

Evelyn Millis Duvall, Ph. D.
Family Life Consultant and Author
Chicago, Ill.

I have no disagreement with Mrs. Duvall. As I stated, my comments on the "nature of parent groups" were "necessarily brief." Of course one deals with parents as persons, but whether we worked with groups from Harlem, Brooklyn, or more privileged Connecticut, with non-English speaking immigrants or sophisticated suburbanites, we found the same basic needs for skilled leadership.

Gunnar Dybwad, J. D.
Director
Child Study Association of America

A NEW ATTACK ON MIGRANT PROBLEMS

A PILOT PROJECT to bring nomadic children and stay-at-home services for children closer together will have been set in motion by the time this issue of CHILDREN reaches our readers.

Leaders in health, education, and welfare in 10 States on the eastern seaboard, meeting in Washington in May, are expected to work out some specific plans of action at a conference called by the Public Health Service, the Office of Education, and the Children's Bureau.

The concern of this group will be the children of migrant families who move out of Florida in the late winter, follow the fruit and vegetable crops up the east coast States to New York, then return for the winter crops in Florida.

These children were chosen for special study not only because they are part of a fairly small, homogeneous group, following a somewhat regular migratory route, but also because there is lively interest and activity in doing a better job for these children in a number of the States they touch.

States asked to send representatives were New York, New Jersey, Pennsylvania, Delaware, Maryland, Virginia, North Carolina, South Carolina, Georgia, and Florida.

Some of the practical interstate tie-ups that the Washington conference will explore, in an effort to break down the isolation of these children and to woo communities and children into closer kinship, are these:

How can these States interweave their services so that each builds on the work the others do for these children?

Can Florida, for instance, identify those expected to migrate; get them ready, through physical examination and immunizations; provide them with health records that can be used en route; arrange for the States ahead to locate those needing health follow-ups and treatment?

Between them, can these States provide better articulation of school experiences, from school to school, from State to State? Can better record forms be developed which the youngsters carry with them to guide teachers in their programs?

Can a better job be done to identify services that migrant families themselves want, and to increase community acceptance of them?

A Joint Committee on Migrants, with membership from the three inviting Federal agencies, in the United States Department of Health, Education, and Welfare, has been formed to backstop the efforts of the States in this pilot project.

CHILDREN will report on developments in later issues.

Florida, a "sunshine State," takes a look at some of the darker sides of life within its borders, and works to do something for its . . .

MOPPETS WHO MIGRATE

DOROTHEA ANDREWS

THE TOWN DUMP is piled high with beer cans, and the whole unsightly mess is only partly obscured by palmettos. Out past the dump, in a little clearing, there is a tent, covered with burlap and canvas.

In it live a migrant agricultural worker, his wife and their four children.

The screams of a child could be heard coming from the tent as we drove up in the clearing. A boy of about eight emerged, holding a leather belt in his hand.

"What are you doing, sonny?" we asked.

"Trying to make these hard-headed kids behave," he said. Out came the "hard-headed kids"—all three of them—with their dirty faces turned questioningly in our direction. None seemed more than 5 years old.

"Why aren't you in school?" we asked the eldest.

"I have to stay home and mind the babies," the little boy said.

Why does a community let a thing like this happen? The community—in this case Immokalee, Florida—"let a thing like this happen" because during the past 5 years, it has been inundated by thousands of people who have enlarged its normal 800 population past the bursting point. They came to Immokalee seeking work at harvest time, which is about 6 months each year. The town is simply not equipped to cope with them.

What are the parents of these children thinking of? They are thinking about earning money. Earning enough money is the obsession of migrant workers. To get it they will put up with little or no sanitation, little or no housing, a diet of cold rice, cold beans, cold cornbread. Their children, also, must put up with a bad diet, bad housing, with at best uncertain schooling.

The little boy in Immokalee is not a special case. Hundreds of boys and girls of school age are staying home to "mind the babies" while their parents work in the rich-loamed fields of Florida.

But hundreds of others are going to school. Some are finishing high school, and some are turning to other vocations and away from the migratory pattern which their parents follow.

Florida has the problem of migratory agricultural workers to a greater degree than any other single State on the east coast. It is from this State that workers fan out into the migratory stream on the east coast and into the midwest. Because Florida has so many diversified crops, and such a long harvesting period, migrant workers can hope to find work in the State for 6 to 10 months of the year.

This report, largely through the examples of Immokalee where it has been possible to make the least advances against the problem, and of Palm Beach County where much has been done, will attempt to describe some of the ways in which the problem of the migratory worker manifests itself in Florida, and some of the ways in which State and voluntary agencies are trying to meet it.

The Florida migrant worker himself is not easy

"Provision of adequate health services for migratory agricultural laborers and their families has been a serious problem for the Florida State Board of Health since vegetable growing first became an important industry more than 20 years ago. Much has already been accomplished in the older and better established growing areas, but much remains to be done especially in newer areas. Other Florida State agencies, such as the Department of Education, are keenly aware of this problem and are interested in improving and extending services within their respective fields. The current interest of both State and Federal agencies is certainly encouraging and will undoubtedly result in further progress if their efforts can be effectively coordinated."

WILSON T. SOWDER, M. D.
Health Officer
Florida State Board of Health

to describe. He may be white, Negro, Texas-Mexican, Puerto Rican, Bahaman, Jamaican.

How many migrants are there? Nobody knows. The estimate is that between 60,000 and 70,000 workers with wives and children migrate to Florida each year for agricultural work. But how many of the wives and children of these workers also work is not known. The estimate is based on those who register for work with the State employment office. It does not take into account the "free wheelers," who drop in from nowhere, pick up work as they go, who may live in the community, in a labor camp, or "squat" on unoccupied land. How many free wheelers there are is anybody's guess.

Migrant Patterns Differ

Where does the migrant worker go when he leaves Florida?

If he is white, he probably came from one of the southern or southeastern States. An estimated 50,000 Florida migrants, both white and Negro, are from the eastern seaboard and southeastern States. The white migrant may come to Florida to supplement his meager earnings in agriculture or textiles in his home State. In the off-season, he leaves Florida and goes back to his home base. If he is a true, year-round migrant, he usually follows the midwest migratory stream, pushing up by way of Arkansas and Indiana into Michigan for the fruit picking season.

If he is Negro, he is more likely to be a year-round migrant, and will join the east coast migratory stream, working his way up through the Carolinas, and into the middle Atlantic States until he gets to New York in the late summer and early fall, then start the backward trek to Florida again.

If he is one of an estimated 6,000 Puerto Ricans, he will probably follow the east coast stream.

If he is a Texas-Mexican—estimate, 2,000—he may stay in Florida year-round, picking up supplemental employment where he can.

If he is one of the estimated 10,000 "offshore" workers from the Bahamas and British West Indies, he is hired on a contract basis, and returns to his home base during off-season.

What are the migrant's problems? To himself, the major one seems to be making enough money to live on. He lives from hand to mouth because of the uncertainty of future employment.

To the community, the migrant is a housing problem. To the health department, he is a health and sanitation problem. To the school authorities, he is a school problem. To the welfare department, because of Florida laws regulating eligibility for public assistance, he is an occasional problem on an emergency basis.

To the growers who employ him, and to the Nation at large, the migrant is an economic necessity to harvest crops of cotton, citrus, cucumbers, potatoes, cabbages, strawberries, corn, celery, tomatoes, sugar cane, beans and other vegetables.

Grower Has Annual Gamble

While the migrant worker gambles on future employment, the grower, for whom he works, is engaged in a bigger gamble of his own. Every time he plants a crop, he stands to "lose his shirt."

If he is to bring in a money crop, he must have several things in his favor: the weather must be good, with no serious freezes; there must be just the right amount of water for his crops, with no heavy rains close to harvest; migrant labor must be on hand in plentiful supply at harvest. If migrant labor is in short supply, the grower must pay top labor prices, although he cannot increase the price of his crop in proportion. If the grower's crop is a little late in coming in, he knows the migrant worker may be on hand one day and gone the next, to harvest another crop where he will get "first pickings." Every year, one or more of these factors doesn't work to the advantage of some growers.

Growers in most parts of Florida have a better chance to win on their gamble than do growers in Collier County, a less fertile and well-developed

land area. Collier County, of which Immokalee is a part, is largely owned by a few interests that are not willing to sell their land, but will enter into annual lease agreements.

Collier County Has Special Problems

The Collier County leasing grower knows that any improvements he makes on the land will figure in next year's price. Yet a number of growers decided a few years ago that they could "make it" even with the added gamble which cultivation of the land presented.

As a result, Immokalee has seen a 5-year influx of migrants, equally divided between whites, Negroes, Puerto Ricans and Texas-Mexicans, who heard by the grapevine that the town had a labor shortage. The migrants are packed into malodorous, tiny cubicles with indescribably meager living arrangements. Two complete blocks of shacks are served by a single outdoor spigot. Everything from an abandoned bus to a piano box serves as "home."

As a result, the facilities of the unincorporated town of Immokalee have been taxed beyond limit. The crisis brought about establishment of a part-time health department but residents must travel 35 miles to the nearest hospital. The county commissioners have set aside $600 from their welfare budget to help in frequently arising emergencies.

Because Immokalee has more migrant workers during the harvesting season than the need justifies, about 90 percent of the growers bid for the help they need on a daily basis. They may ask for bean pickers at a rate varying from 50¢ to $1.15 per hamper, depending on the labor supply. The grower's responsibility for his pickers ends when he brings them back from the fields at night.

In some areas, growers have tried to provide rent-free housing for their workers, with the stipulation that they seek no other jobs as long as the growers need them for their own crops.

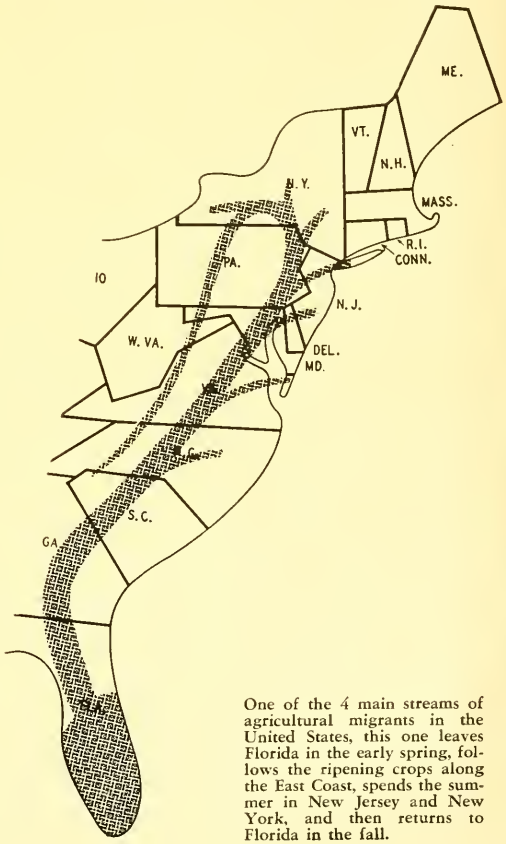
Few Immokalee growers provide such housing. Last year they had a bad year, and it is not realistic to suppose they will invest in housing on leased land to any great extent unless and until they show a substantial profit for their crops.

Collier County is further disadvantaged because it is not the site of one of the migrant labor camps built under Federal sponsorship in the early '40s to house migrant agricultural workers.

In the Everglades area in Palm Beach County, for instance, five labor camps for migrant agricultural workers were built by the Farm Security Administration and operated during World War II by the War Food Administration. They represent the best housing available to migrants. When the Federal Government moved out of the housing picture after World War II, local housing authorities took over the camps and are continuing their operation.

Two of the Palm Beach County camps are located in Belle Glade. One, for white migrants, houses 1,000 people. The other, for Negroes, houses 2,000. Rents range from $3 to $10 per week, depending on size and construction of the units.

The camps are well-kept, with turfed grounds, and community laundry and toilet facilities. Each of these 2 camps has a school on the grounds, and a health clinic staffed by a public health nurse from



One of the 4 main streams of agricultural migrants in the United States, this one leaves Florida in the early spring, follows the ripening crops along the East Coast, spends the summer in New Jersey and New York, and then returns to Florida in the fall.

the Palm Beach County Health Department.

Camp managers estimate that of the whites living in the Belle Glade camp, less than 2 percent are migrants in the old sense. Many former residents of the camp have moved into permanent housing in the town of Belle Glade. In the Negro camp, an estimated 30 to 35 percent are year-round residents.

In both camps, there is a heavy demand for standby rental agreements, by which tenants leave the project for part of the year and pay a reduced rental to hold their dwellings.

The Belle Glade Housing Authority is considering expansion of its housing operations, not by enlarging the camp, but by building permanent low-cost housing within the Belle Glade area.

For existing housing is by no means adequate. Belle Glade has grown in permanent population from about 4,500 in 1940 to 7,000 in 1950. The area is annually swollen by an additional 12,000 (estimated) migrants during the harvest season, about 65 percent of them Negroes.

Some of them live in migrant camps, some in growers' quarters, some in privately owned housing. The county health department in March of this year surveyed quarters offered to migrants by 24 growers in one section of the county and rated them "Poor" in 54 percent of the housing, 50 percent of water supplies, 92 percent of sewage facilities, 88 percent of screening facilities, and 100 percent of garbage disposal facilities.

Because of the number of private growers' quarters and their scattered locations, county health department officials estimate the full-time services of at least 3 sanitarians would be needed to inspect growers' quarters and the large migrant camps in the county each month.

Much of the privately owned housing available to the migrants is even more substandard. A stone's throw from the well-kept white camp at Belle Glade is a collection of shacks, fully occupied, where migrant workers are paying high rents for less than basic housing and sanitary facilities.

Another factor in the housing situation is the apparent preference of many Negro migrants for living—even in substandard housing—in Negro communities rather than in migrant camps. In one Glade town, many Negroes clamor for space in "Streamlined Quarters," even though it offers crowded housing and primitive sanitary facilities.

A county health department sanitarian tells how he tried to get a "Quarters" property owner to build flush toilets for community use. Later, when the whole area was threatened by fire, the sanitarian wryly recalls standing, with garden hose in hand, determined to save the newly built toilets from destruction. He was successful, although some of the housing did burn.

In both camps and growers' quarters, where public toilets have been supplied, there has been both abuse and misuse, as there often is in filling-station facilities used by much more affluent migrants. However, many of the migrants do not know how to use toilets, and resort instead to open areas in the vicinity.

The Palm Beach County Health Department believes that while it has more problems with its resident population than with the migrants, the number of migrants with problems is proportionately greater than that of the resident population of comparable economic status. The migrants' problems therefore are given priority.

Migrants' Needs Illustrated

Here are two case histories which illustrate some of the needs of migrant workers who come into the county, as written by a public health nurse:

"In 1950 I first became acquainted with the H. family. They were a small family with 2 children, who arrived from Alabama where they picked cotton. The children were then 3 and 4 years old. Mrs. H. needed dental care badly. The 3-year-old child needed a hernia repair and the doctor said it was dangerous to delay.

"But before anything could be done they were off to Michigan to pick apples. Back again and Mrs. H. is pregnant, 7 months, no prenatal care. She apparently had been pregnant when she left here. Crops are poor, so she is delivered by a colored midwife whom they forgot to pay. After 5 days I'm summoned to the house and find the mother has a temperature of 105. No food, no work for the husband. There was a freeze that season.

"Finally the Home Missions Council came to their aid, and Mrs. H. was hospitalized. She recovered after a long illness, but before dental care could be obtained for the mother, or surgery for the girl, now 4, they're off to California, new baby and all.

"The fall of 1951 and here is the H. family back again. By now, the father has had an automobile accident, and has an injured back, both younger children need hernia repairs badly, and Mrs. H. still needs a set of teeth, but Florida residence was never established, so they aren't eligible for any help. The middle girl finally has a strangulated hernia, and a

local civic organization helps pay for the operation. The baby had whooping cough because mother could never quite get to the clinic on time for immunization. The H. family is gone again, but they will still have their problems (plus new ones) when they return in the fall.

"Then there is the C. family, with 8 children ranging from 1 to 12 years and no father, who arrived from Arkansas. Jimmy, aged 10, has rheumatic fever. The mother needs V. D. treatment. All the children need dental care. Two need tonsillectomies, and the baby has rickets, since the diet consists mainly of cornbread. This family has so many problems, and there is so much to be done for them, yet they soon are off to New York to pick apples."

County Reports Health Progress

The Palm Beach County Health Department, since its organization in 1948, has moved on several fronts to better the health of the migrants.

It set up a low-cost maternity program in a deliberate move to compete with unqualified midwives in the county and reduce infant mortality. Many migrant women have taken advantage of the plan under which they get 2 days of hospital care for rates varying from $25 to $30, with a doctor charging a like amount for delivery. The number of midwives in the county has been reduced and those now in practice have undergone a training and internship program.

On the staff of the county health department is a sanitary engineer to improve the housing and sanitation of the migrant workers.

The county's four health centers all are located in migratory labor camps. Although the migrants have the benefit of public health nurses through their clinics and home visits, estimates are that, to meet the migrant need alone in the county, four more public health nurses should be added to the staff.

The job of seeing the migrants where they are is a problem in itself. A public health nurse in the county found, on one grower's property, 24 infants on a double bed, being cared for by an elderly woman while the children's mothers worked. With the cooperation of the grower, the nurse developed some basic standards for a day nursery at the camp. The grower pays the salary of a worker who operates the nursery under the supervision of the nurse.

The county school system also has moved in on the migrant problem. The schools in the migrant camps are an integral part of the school system. One of these is a school for exceptional children. In this county, as elsewhere, there is overcrowding in the school system, but the migrant children appear to be neither more nor less disadvantaged by this situation than are the resident children.

The welfare department plays a limited role in the life of the migrant. The department has a worker in the Everglades and two in West Palm Beach, who operate only in the specific areas of aid to dependent children, old age assistance, and aid to the blind.

In this modest cabin, known as "Children's Village" in Immokalee, as many as 30 children are provided with "day care" while their parents work. The children may arrive anywhere from 6 to 8 o'clock in the morning and stay until their parents return which may be late evening. The Village is staffed entirely by volunteers who work under the guidance of the Florida Ministry for Migrants. The children are fed a morning snack of fruit juice or milk, and get lunch each day. If they stay for an evening meal, their parents pay 25 cents extra. This is the second year for the Village.

(Photos by Mel Kenyon, *Miami Herald*.)

A Protestant interdenominational group, the Florida Christian Ministry to Migrants, also has moved into the picture and operates services at 10 points in the State where the migrant problem is heavily centered. Four of these are in Palm Beach County.

The Ministry, which started about 25 years ago on the Eastern Shore of Maryland, now attempts to help the migrant worker wherever he may be, whether on the east coast or in the mid- or far-west.

In several areas the Ministry has day-care centers for preschool children, a recreation and handicraft program for teen-agers, and a depot for migrant women who do not have the necessary maternity clothing.

Religious services are conducted by the Ministry, but migrants are encouraged to go to church in the community if services are held there.

The Ministry also helps with the migrant's welfare problems. A teen-age expectant mother, deserted by her husband, was helped by the Ministry which found and returned the deserting husband, helped locate a job for him, arranged separate housing for the couple, and helped with the woman's confinement arrangements.

The children in migrant families have been described by a Palm Beach County nurse as living "very close to death, birth, and danger."

In the Belle Glade housing camp, a survey was made recently to find out what kind of diets the children had. An astounding number of first-graders reported they fixed their own breakfasts, knew how to make biscuits.

Nutrition is a chronic problem with migrants. In areas where they help pick citrus, the growers have offered them all the fruit they can eat if they will pick it. They do not take advantage of the offer to any great extent. Many of the children get an infinitesimal quantity of milk. In some migrant camps, milk is brought into school each day through arrangement with a local dairy.

Some preschool children, left in the care of older children, are exclusively bottle-fed. Older children eat what is at hand and easy to prepare.

Migrants Not Fully Accepted

Community acceptance also is a problem. In Palm Beach County, some progress has been made in breaking down the barriers between the migrant and the community but the boundary line still exists. Belle Glade children who graduate from the "camp" elementary school and go to the town high school are still called "camp" children, even though the children in other migrant families, living in Belle Glade itself, are accepted in the school as "town" children.

But there is some evidence of a growth in community awareness by the migrants. At the Belle Glade housing project, authorities are tremendously proud of the fact that the camp school has a parent-teacher association—a rarity in migrant settlements—and that a few men attend the PTA meetings.

In some areas, the migrants publicly show how they feel about community rejection. On one migrant worker's hotrod is the scrawled sign: "Don't laugh, lady, your daughter might be in this car."

Southern Florida has recently seen a particularly heavy immigration of one of the four migrant groups, the Puerto Ricans.

The Puerto Ricans were told, in advertisements appearing in Island newspapers, that there was full employment, big money to be made, plenty of housing in the States. They were promised a plane ticket, food, and shelter if they wanted to take advantage of these opportunities.

Many responded to the ads. The persons who promoted this labor importation charged the Puerto Ricans for their plane tickets and for all subsequent expenses they incurred, apparently hoping to make a profit by exploiting them as a labor force. The Puerto Ricans very naturally resented the situation which they found on arrival: few jobs, no housing, no "big money." This situation is being investigated by State law authorities. But the promoters of the scheme already have given Dade County health and education officials a vexing problem.

Some Encouraging Signs

Some of the migrants seem unwilling to take advantage of the meager community facilities which do exist. Families living near the Belle Glade camp in Palm Beach County have been encouraged to bring their preschoolers to the camp day nursery operated by the Florida Ministry to Migrants, yet many apparently prefer to keep their school-age children home to tend to the "babies."

There are, however, among migrant families, increasing numbers who arrive in time to enroll their children in school in the fall and do not migrate again until school is out. These parents seem to place a high value on a high school education. But many other parents place a higher value on the economic asset their children represent during the harvesting season, and not only permit but con-

done their chronic absences from school to work in the fields.

The problem of records is a fretting one to all official agencies who deal with migrants. One boy who finally finished high school in Palm Beach County had been to 17 schools in 5 States during his school life. The principal of the last school was hard pressed to gather the necessary information so he could award the boy his diploma.

Many women who come into prenatal clinics have no record of previous examinations. Those from some northern States can usually show some evidence of previous medical care earlier in pregnancy, because employers in these States encourage them to attend clinics. Most from southern States have had no previous clinic care. Most of the women go back to work in 3 weeks to a month following delivery, usually without a post-partum examination.

Many migrant families, because of their precarious employment, make no effort to follow a budget, and may quickly spend their hard-earned dollars for luxuries without allowing for family emergencies or sickness.

Workers for the Florida Ministry are trying to develop a budgeting sense with some of the women. In addition to teaching them how to add, they also are teaching them how to use a phone, how to read a menu in a restaurant.

Many of the workers, when they get sick, descend on the few available doctors for service, for which a high proportion do not pay, either because they do not have the money or do not feel a sense of obligation.

Palm Beach County health officials believe that if the department staff were augmented by medical social workers, they might be able to tackle the broad problem of medical social services to the migrants, from the standpoint both of regular and emergency medical care and of the individual family's economy.

These officials believe also that all agencies which deal with the migrant problem on a community basis should meet together as an inter-agency group to exchange ideas and information. This pattern, they think, can be applied not only at the community but at the State and inter-State level.

The Size of the Problem

To sum up:

State health authorities in Florida have recognized the problem, but their funds are not adequate to cope with it, and their programs do not meet needs fully.

State education authorities are trying to absorb the migrant child into the regular school system, and where possible are building additional classrooms to accommodate the overflow.

State welfare authorities, under existing requirements, cannot do a great deal to help migrants. Eligibility for public assistance is based on a year's residence in the State, and 6 months in the county.

Assistance to migrants by voluntary agencies is largely limited to the activities of the Florida Ministry.

It would appear that some of the most pressing unmet needs of the migrants and their families are a program of health and general education for both adults and children: some form of welfare aid similar to that which is available to residents; provision of basic housing and sanitation; and a system of exchange of records within and between States so that the migrant worker and his family can achieve more continuity in living.

The community, the official agencies, and the growers need more information about the number of migrants, particularly a figure to show how many migrants join and how many leave the seasonal worker stream each year. They also need a better idea of how many "free wheelers" there are, so that the labor supply can be estimated more accurately.

Each community which has a migrant population needs to recognize that these migrants contribute to the economy of the community, and that therefore the community must share some of the responsibility for them.

These are more or less tangible parts of the picture. So far as the State of Florida is concerned, there is still another factor which may grow in importance. Improvements in agriculture, developments in processing, canning, and quick freezing, and the possibility that rice may become a year-round crop in the State, all may lead to a situation eventually where Florida might be able to offer year-round employment to many of its now migrating workers.

If Florida should solve its migrant problem by absorption, this problem would be no less in other States that have shorter harvesting periods and just as urgent needs for workers.

In all this complexity of social and economic problems, one fact should not be lost sight of: as long as the migrants are badly fed, poorly housed and uneducated, it will be the children who will be most disadvantaged.

"Old hands," now, at using their artificial hands, these 3 youngsters—the boys aged 5, and the girl 3—recently demonstrated before a meeting of the American Academy of Pediatrics that an artificial limb program can help greatly in giving handicapped youngsters the chance for a normal life. Fitted with prostheses by the University of California, Los Angeles, these children have also had treatment at the Marion Davies Pediatrics Clinic in that city. (Photo courtesy of *Los Angeles Times.*)

ARTIFICIAL LIMBS FOR CHILD AMPUTEES

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THERE IS NEW HOPE AHEAD for the child who is missing an arm or leg.

Not tomorrow, or the next day, but in the reasonably near future it should be possible for him to have a substitute limb that will work as efficiently as artificial arms and legs can now be made to function for adult amputees.

Such a prediction could not have been made even 10 years ago. What makes it possible today is the extraordinary progress that has been made for adults under the leadership of the Advisory Committee on Artificial Limbs of the National Research Council.[1]

Since its start, the Advisory Committee on Artificial Limbs has received financial assistance from the Federal Government's Office of Scientific Research and Development, the Army, the Navy, and the Veterans Administration. In 1948 Congress implemented this program on a permanent basis by enacting Public Law 729. This act ". . . to aid in the development of improved prosthetic appliances . . ." authorizes an annual expenditure of $1,000,000 and names the Veterans Administration as the agency to administer the fund. The act also authorizes the Administrator of Veterans' Affairs ". . . to make available the results of his investigations to private or public institutions or agencies and to individuals in order that the unique investigative materials and research data in the possession of the Government may result in improved prosthetic appliances for all disabled persons." By this action, the Congress insured continuity to organization and personnel which was needed if the program was to attain its goals.

Great strides have been made in the last decade in the artificial limb industry. Ten years ago little was known about these problems. The person who had lost a leg could be supplied with a device—or prosthesis, as the appliance is called—that would at least enable him to move about, provided it was properly fitted. But it was another story for the person who had lost an arm. He faced an acute rehabilitation problem. The chances were that he would return to his work—or be forced to seek new employment not requiring the use of both hands—with an empty sleeve, or at best be fitted with a sub-

stitute arm that was little more than a means of deceiving the eye—or trying to.

Today, after 8 years of research and development, artificial legs have been greatly improved and artificial arms have been developed that allow the performance of all the major motions of the arm and hand used in everyday living. This has meant a constant improvement in devices for the control of grasping and of wrist and elbow movements. The goal of all this research has been to make the amputee a 2-handed individual and to provide him with a prosthesis that was comfortable to wear, easy to operate and maintain, and that satisfied the individual functionally and cosmetically.

The cost and time involved in such research ruled out the possibility that any one organization or artificial limb manufacturer could undertake it. It could come about only as it did, through the unique teamwork of government, manufacturers, and professional workers—these last running almost the alphabetical gamut of artists, biologists, chemists, engineers, physicians, physiologists, psychologists, and physical and occupational therapists.

A great deal more research will have to be undertaken before the Advisory Committee on Artificial Limbs working in cooperation with the Orthopedic Appliance and Limb Manufacturers Association can apply the knowledge it now has to the problems of the child amputee. This will involve all the specialists required for work with adults as well as child specialists, the children themselves, their parents, and school authorities.

A child amputee research program, to be conducted at various places in the country, with the Advisory Committee on Artificial Limbs of the National Research Council serving as coordinator, is now being planned. The adult research program already in operation can be expanded to include the child amputee in their study. According to this plan, research would also be conducted by the Michigan Crippled Children Commission at the Mary Free Bed Children's Hospital and Orthopedic Center, Grand Rapids, Mich., and by the University of California, Los Angeles, at the Marion Davies Pediatrics Clinic. Since the start of Michigan's Juvenile Amputee Training Program in 1946, approximately 300 children have received training there in the use of artificial limbs. The project at the Marion Davies Pediatric Clinic is a research program in the developmental problems of the child amputee, started during the summer of 1953, and conducted jointly by the College of Engineering and the School of Medicine of the University of California, Los Angeles.

From the beginning, members of the Advisory Committee were aware that by confining their work to adult amputees a big part of the problem would be left untouched. But circumstances made it imperative that the initial work be concentrated on adults. World War II produced some 17,000 amputees among servicemen. Another 170,000 civilians suffered injuries in war industries that resulted in amputations. They, too, were casualties in the service of their country. These thousands of young men and women needed better help than was available to them at that time.

In 1945 the Surgeon General of the Army made the first move in tackling this problem. At his request the National Research Council set up a Board for Prosthetic and Sensory Devices. After 2 years of investigation and experiment the present program on artificial limbs was organized through the facilities of the Veterans Administration and the Armed Services.

Today research and development are being carried on at the Army Prosthetic Research Laboratory, Walter Reed Army Medical Center; the University of California, both at Los Angeles and at Berkeley; the United States Naval Hospital, Oakland, Calif.; and the Veterans Administration Prosthetics and Testing Development Laboratory, New York City. The New York University Psychological Testing Laboratory is responsible for overall evaluation of devices and techniques under normal conditions.

Two standing subcommittees of the Advisory Committee give general technical guidance, one on lower, and the other on upper extremity prosthetics. Each is composed of specialists in the fields of medicine, engineering, prosthetics, and many other professions that contribute to the rehabilitation of the amputee. These subcommittees review progress, define requirements, and recommend action to the Advisory Committee which in turn advises the Veterans Administration, the Orthopedic Appliance and Limb Manufacturers Association, and others interested in the problems of amputees.

Although the program was set up initially with the needs of veterans and war plant workers in mind, the findings benefit all kinds of amputees. As soon as a device is acceptable to the researchers, it is made available to the general public through commercial

manufacturers. Veterans represent only about 3 percent of the amputee population of this country which is thought to number close to 1,000,000. No count of the child amputee population has been made, but amputation of one or more extremities in children occurs more often than is generally supposed. Some children are born with one or more limbs absent; others suffer loss through accident or disease.

Of the 300 child amputees cared for by the Michigan Crippled Children's Program in the past 7 years, 40 percent were born with limbs missing and 60 percent had lost arms or legs due to accident. The need for artificial arms was 3 times as great as the need for artificial legs.

The first essential in the care of a child amputee is the family, because it is the family who must provide the supervision. It was found in the Michigan program that a child would accept a prosthesis readily enough when his parents were convinced of its importance but that supervision of the child, at intervals of 3 months, was necessary to maintain the prosthesis in repair and prevent the development of bad habits in its use.

A great deal of research which is already benefitting adult amputees lends itself to treatment of the child amputee. In fact, many of the items of the adult armamentarium now available can be used satisfactorily in fitting children. In some instances these items would require no alteration; others would have to be scaled down to child size. But before major gains can be made, research directly relating to children is urgently needed.

Designing child sized hands, small elbow units, and other parts would be the least of the problems. A plastic material that could be remolded, cut, or lengthened as growth occurs might have to be developed. More important still, studies would have to be made to determine which types of hands, wrists, and elbows should be applied to different types of child amputees through various age groups.

Without guidance most child amputees do not wear a prosthesis and reach adult life convinced that they do not need one. For best results children should be fitted at the earliest possible age. Sufficient information is not now available about the age at which a child should be fitted or the type of prosthesis which would be suitable for the young age groups. But many children, both arm and leg amputees, have been successfully fitted under the age of 2 years.

Research, treatment, and training are inseparable and not much is known about the training of very small, handicapped children. It is possible that a simple, glovelike device that enables the child to hold an object against his normal hand would be sufficient at first. A mechanism for grasping that would be safe for a young child to use would come later. More complicated prostheses involving wrist rotation, elbow locks, and finer manual dexterity would be added as the child's motor development made them advisable. Training would have to take into account the physical, mental, and psychic development of each individual child. It would involve cooperation of the parents who themselves would need special guidance. In the case of an infant, training would be directed to simple tasks, and as the child grew, to the more difficult motions involved in self care, play, and later in work. This would mean selecting tasks that are possible for the child to perform at various ages, motivating him to perform these tasks, and supplying him with the mechanical aids which his age and development permit him to operate easily. The facts can only be learned from experience in fitting and training child amputees.

Biomechanical studies as they relate to children would have to be made. All improvement in prosthetic replacement grows out of such time and motion studies of normal persons and amputees. Beginning early in the adult program, and in continuous progress ever since, arm movements made by a normal person and those made by an amputee wearing a prosthetic device have been investigated. These studies brought to light a wealth of needed information. They revealed altered or substituted gestures that are peculiar to the amputee. They also showed differences in speeds, forces, and skills. While a great many of these facts are immediately applicable to children, more specific information would have to be gathered as the program expanded.

The psychological impact of the loss of a limb varies somewhat with the individual. It may also vary with the age of the child and the attitude of his family. The full import of such a loss is not known and psychological studies would have to be made. Does the child's injury tend to make him withdrawn or antisocial? Does it inhibit the normal development of self-confidence and independence? To what extent does the prosthesis meet these problems?

Experience in the adult program has shown that the most effective service to the amputee can be given

The prosthetic research program for child amputees, projected in this article, can build on effective work that has already been done with a few children, and multiply and improve it for the benefit of many. This small bilateral amputee, less than 3 years old, shows that even very young children can be fitted with prostheses and do most things normal children of that age do. As he grows older, this youngster can be fitted with wrists and hands which the projected research program is expected to perfect and test.

only through a prosthetic clinic with a physician, physical and occupational therapists, prosthetist, and other consultants if needed, acting as a team, consulting together with the amputee and sharing their knowledge and skills toward his rehabilitation. In fitting adults it has been found that many circumstances have to be taken into consideration. What type of amputation does the patient have? How well is he able to use the stump of his arm? How strong is it? Is his physical condition good? What type of work is he in? What is his attitude toward wearing a prosthesis? Considerations such as these and many others have to be evaluated before the prosthetic prescription can be written. This requires the services of a team.

The physician serves as the head of the team. The type of service and prosthesis is usually arrived at through consultation of all members of the team but final prescription is the physician's responsibility. The physical and occupational therapists are primarily responsible for the therapeutic exercises and training the amputee in the use of the prosthesis, as prescribed by the physician. The prosthetist fabricates and fits the prosthesis as prescribed. Each child prescription team would have as members, in addition to these workers, a psychologist or a psychiatrist, and a medical social worker.

The team is also responsible for checking out the prosthesis, for seeing that it meets certain standards and that the amputee is able to use it effectively following training.

But the study does not end when the amputee has been fitted and taught to use his prosthesis. The Advisory Committee found that they could not always get dependable answers from the adult amputee, after he had been using his prosthesis under normal home and work conditions, to such questions as: How valuable in this prosthesis? What can the wearer do with it? What can't he do with it?

Some measure of performance was needed. To develop such standards, another facet of the artificial limb program came into being.

Today adult field studies are conducted on a Nation-wide scale under the supervision of the Prosthetic Devices Study, New York University, to determine whether a prosthesis which was judged satisfactory under controlled, laboratory conditions stands up under normal, daily living conditions. Before any device is given final approval and recommended by the Advisory Committee, it is turned over to New York University to be given a field test.

Followup evaluation tests applicable to children would have to be developed for the determination of prosthetic functions. These would be similar to the tests developed for the adult amputee, although undoubtedly they would be more complicated and more difficult to apply. Children would probably have to be followed until they reach maturity. Adjustments and replacements for the prosthesis would be made as needed.

Releasing the device to the public is not enough. Teams of physicians, physical and occupational therapists, and prosethetists must also be trained to apply the research knowledge. A school in upper extremity prostheses was established at the University of California, Los Angeles, in 1953 to train the various types of specialists needed. Ten complete courses have been given to date to teams from selected cities. In the future additional courses will be offered to any teams who want this training.

The California school grew out of a pilot study made in Chicago in 1952. A group of Chicago physicians, therapists, and prosthetists first attended a course in upper extremity prostheses at the University in Los Angeles. When they returned to Chicago a clinic was established which processed 50 amputees, applying the knowledge learned in California. Each amputee's problems were evaluated before and after clinic treatment by a prosthetic team.

A most encouraging fact that came to light in the Chicago study was that 80 to 90 percent of the arm amputees who received team service through the clinic continued to wear their prosthesis. This was also revealed in the Case Study Program which was conducted at the University of California, Los Angeles, in 1950. Psychologically, the amputees showed much improvement and their ability to handle their prosthesis had greatly improved.

A prosthetic program means much more than fabricating prosthetic devices. It means the ability to prescribe the device that will best satisfy the needs of the individual. It means training the amputee to benefit from the maximum functioning of the artificial part. It means helping him to adjust psychologically and socially to his handicap. It is a completely individualized service. And it requires the cooperation of innumerable experts. Work of this kind cannot be carried on by individuals working in isolation. But a program for children can build on the accomplishments for adults which have behind them the full resources of the nation.

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[1] The Council is a technical body, established in 1916 by the National Academy of Sciences, which operates under Congressional Charter. The Council is charged with the responsibility of "conducting research in the mathematical, physical, and biological sciences, and in the application of these sciences to engineering, agriculture, medicine, and other useful arts." Its membership includes not only scientists and technicians, but also businessmen interested in engineering and industry. The Academy and Council are cooperative, quasi-governmental agencies and their research work is financed by the returns from endowment funds, by special grants, and by contracts with other agencies.

"MOVING AHEAD TO CURB JUVENILE DELINQUENCY"

THIS IS THE THEME of a conference which has been called by Oveta Culp Hobby, Secretary of Health, Education, and Welfare, for June 28–30 in Washington, D. C.

The conference will climax 2 years of preparatory work by the Children's Bureau and the Special Juvenile Delinquency Project sponsored by the Bureau.

Purpose of the conference is to review accomplishments to date; define and discuss the most urgent needs at this time; and formulate next steps in a continuing program to meet those needs.

The opening general session will be addressed by Mrs. Hobby, and by the Hon. Robert C. Hendrickson, Chairman, Senate Subcommittee to Investigate Juvenile Delinquency. The Chief of the Children's Bureau, Dr. Martha M. Eliot, will chair the opening session.

Two of the three conference days will be devoted to detailed study in 13 work groups on these subjects:

I. *Knowledge to Prevent Delinquency*

II. *Parents' Role in Preventing Delinquency*

III. *The School Faces Juvenile Delinquency*

IV. *Counting Delinquent Children*

V. *Police Services for Children*

VI. *Providing First-Rate Detention Care*

VII. *Juvenile Courts and Probation Services*

VIII. *Our Institutional Treatment Program*

IX. *Coordination of Services for Delinquent Children*

X. *Training Personnel for Work with Delinquent Children*

XI. *Citizen Action to Curb Delinquency*

XII. *Moving Ahead for Sound State Legislation*

At the final session of the Conference, a summary of findings will be adopted by the group.

A number of basic Bureau-Project working papers or pamphlets will be available to the conferees for their discussions.

Invitations have gone to persons who have been working on the Bureau-Project program over the past 2 years. They include public officials, and representatives of cooperating educational, religious, civic, fraternal, health, and labor organizations, as well as of professional groups.

It is anticipated that 400 specialists will be in attendance.

CHILDREN will report in a later issue on conference results.

District of Columbia uses medical social services in child health clinics in . . .

HELPING MOTHERS HANDLE EMOTIONAL PROBLEMS

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FOR MANY YEARS one of the major tools of the maternal and child health program has been the child health conference or clinic. Increasingly these clinics are places where parents may receive help with the early social and emotional difficulties of their children as well as with their physical health.

The Bureau of Maternal and Child Health of the District of Columbia Department of Public Health put this concept into action very early in its work with mothers and children. The medical staff of that Bureau recognized that social difficulties within the family often threatened the care given the child or created emotional tensions and problems within the child which interfered with the normal process of growth.

For this reason, the Bureau, shortly after its establishment in 1936, added medical social workers to its staff to help with these problems. From almost the start of the program, casework services from a medical social worker have been available to these clinics, first intermittently, later on a regular basis.

During the years, the Bureau and its staff have greatly increased their understanding of the effect that social and emotional difficulties within the family have on the growing child. This article shows the types of emotional and social difficulties encountered in the clinics and how the medical social worker helps the mother with these difficulties—help which in turn benefits the child.

The emphasis of the medical social worker in the child health clinics of the District of Columbia is primarily on helping with those social and emotional problems that interfere with the normal, healthy development of the child. Her activities may include direct social casework services to parents and children and consultation with other staff members and other community agencies. She merges her services with those of other professions in maintaining the physical and emotional health of the child.

The District has 15 neighborhood child health clinics offering health supervision to preschool children. The Bureau of Maternal and Child Health has a small staff of medical social workers headed by a director of medical social service; one medical social worker is assigned to these centers. This means, of course, that coverage is limited, but referrals for social casework services are made to this worker from all the centers.

A large majority of the families using the child health clinics are in the lower socio-economic group and have all the problems usually present in this group, such as substandard housing, and inadequate and frequently irregular incomes. Many are individuals with a long history of deprivation. Often these mothers come from broken homes and have never had an opportunity to develop a warm enduring relationship with another person or to develop their innate potentialities.

In these centers, the physician's health appraisal includes a developmental evaluation of motor, adaptive, and social behavior, language development, and personal habits. The physician evaluates whether or not behavior and development are within normal limits for the child's age and discusses this with the mother when this seems desirable. The public health nurse also sees all the mothers and discusses these things with them. Through this educational process many mothers become well informed about what can be expected of a child at various age levels. But as valuable as instruction is, it does not meet the

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problems of mothers who are upset about personal difficulties or have problems in their families that make it impossible to absorb the information available to them or even to use the knowledge they have.

There are many ways in which medical social workers help these mothers. They help the mothers with their use of the services in the clinic, with difficulties in family relationships which are affecting the development of the child, and with the early recognition of tensions in relationships. They also identify deepseated difficulties and assist mothers in accepting help if such help is available on a sustained basis. Through such help to the troubled mother, stresses and strains are eased, solutions to some problems are achieved, and, in the long run, the child's situation is improved.

In some instances the mother's and child's needs are such that service from another community resource is essential, if they are to have help. In the District the usual social agencies present in large cities are found. As in most social agencies in the country offering skilled services there are long waiting lists, not enough funds to cover all needs, and not enough trained workers. As a result, the best than can be attained is some improvement in the situation.

What are the problems mothers bring to these centers—problems to whose solution medical social workers offer help?

Sometimes an insecure, upset mother may respond to advice regarding the care of her child as if she were being criticized for what she is doing or failing to do. For example:

One young unmarried mother was referred to the medical social worker because her child was malnourished and was not gaining weight despite the efforts of the center to help her with this. The medical record showed that the mother was usually very upset in the clinic and frequently cried. She had said that she could not afford to buy the foods recommended for the child by the center. She was on the verge of tears when she came for an interview with the medical social worker. Although she had been referred for assistance with financial problems, she said she did not need such money and remained totally uncommunicative about what was really troubling her.

Finally the worker commented that something must be wrong since she seemed so upset. The mother started crying and between her sobs revealed that she did not want "to be bothered all the time."

"What is it here in the clinic that bothers you?" the worker asked. Eyes cast down, the mother said slowly, almost in a whisper, "They keep telling me that the baby isn't doing well; I know he isn't doing well, I know that, but I don't want to be told this all the time. I'm doing everything they tell me."

The worker asked if the recommendations had sounded like criticisms to her. "My friends keep asking me why I come since the people here keep saying things to me all the time," she replied.

"It isn't that I haven't had the money to do it—and I've followed the doctor's suggestions in feeding him. It isn't my fault that he doesn't gain."

Evidently the mother had construed the suggestions made by physicians and nurses as criticism of her care of the child. Her way out apparently had been to say that she did not have the money to follow through on these recommendations so they wouldn't think she was an inadequate mother.

The worker commented, "The doctors and nurses are concerned and want to help you. You seem worried and upset and perhaps this makes it difficult for you to care for the baby—and he may be reacting to the way you feel, too."

This last remark seemed to free the mother enough to talk about things that were bothering her. She started to talk about the father of the child—and immediately became quite choked up with feeling. He was living in another State and was showing no interest in her or the child. At this point the mother was unable to go on.

Because this mother was so deeply disturbed and unhappy the worker knew that many months would be required to help her feel less anxious.

In preparation for the mother's next clinic visit, the worker talked to the doctor and the nurse about the mother's feelings and her need for reassurance and encouragement.

On the next clinic visit two weeks later, the child showed an appreciable gain in weight for the first time in 3 months, and the mother was commended on the child's improvement. The clinic recommended that the child get a special, rather expensive type of milk and the mother accepted financial help with this for one week. Later she arranged to take care of this responsibility herself.

The next visit showed the child had continued to gain weight and the mother expressed surprise and pleasure with this improvement. She seemed much more relaxed and listened carefully while further recommendations for the child's care were discussed. She was very proud of the child's improvement and the staff's recognition that she was responsible for it.

During the last two interviews and the ones that followed, the mother was able to talk more freely. She stated that she was very hurt that the father did not marry her after she became pregnant. Since she had been talking with the worker, she was feeling better than she had for a long time and she thought it best that she try to forget about him. This affair had "messed up" her life and ruined her plans for an education. She had returned to school after the birth of her child but was unable to continue because

she had no one to care for the baby.

The worker wondered whether it might not be possible to work out plans in the future for the mother to go on with her education. The mother brightened at this possibility and said she certainly would appreciate any help the worker could give her with such plans.

Although all the mother's problems had not been resolved, she had been freed to talk about the things that prevented her from giving good care to the child. The worker's non-blaming and understanding attitude had relieved her tension and made it possible for her to be less tense with her baby. The baby in turn responded to the changes in his mother and gained weight. The worker would continue the interviews with the mother until she gained more confidence in her ability to meet her own problems and plan for the future.

Many mothers are concerned about thumb sucking, nail biting, masturbation, feeding problems, aggressiveness toward a younger child, whining, and negativism. The worker can evaluate the behavior with the mother and help her determine whether the behavior is within normal limits, in which case the mother feels reassured by the interview and feels that "talking it over has helped me," as one mother commented after an interview concerned with the symptoms of jealousy her 2-year old was showing.

Most mothers understand jealousy when it is expressed directly through overt action, for example through the child's attempting to push the baby off the mother's lap or wanting to be held whenever the baby is held. But they do not always understand so well a child who shows his jealousy indirectly by regressing in toilet training or wanting a bottle again after having been weaned without difficulty some months previously. Sometimes they are not quite sure how they should handle a child who shows love for the new baby 1 minute and the next minute wants to hit him in the face.

Some mothers may not recognize a behavior difficulty or may be reluctant to admit to themselves that any exists. Others may express concern about the behavior and seek some simple treatment in the form of easy-to-follow advice that will clear up the situation. Even when mothers recognize the symptoms, often they have not yet reached the stage where they consider the behavior serious enough to be seeking help and may not have thought of the clinic as a place where emotional as well as physical factors are considered.

Behavior problems of children in the child health clinics have ranged all the way from the relatively common but sometimes excessive jealousy an older child feels toward a new baby to the psychotic behavior of a 4-year-old who finally had to be admitted to a mental institution. The latter, of course, is exceptional. Most of the problems encountered are excessive manifestations of a normal trait of behavior at a given age which might be considered abnormal at a later age, if no help were given.

Often behavior which in itself may not seem grossly abnormal may be indicative of serious disturbances in the life of the child. For example:

Three-year-old Mary was whiney and apprehensive in the clinic, constantly clinging to her mother. The mother reported that Mary had a poor appetite, did not sleep well, and complained of pains. Upon examination the doctor found no physical basis for these symptoms. Suspecting that the root of the difficulty lay in the home situation, the doctor referred the mother to the medical social worker.

The mother said that Mary is an only child, so has no playmate in the home. She is not allowed to play much with other children because her parents say that she does not get along with them and sometimes they hurt her. She cries if her parents leave her with someone while they go out, so the father refuses to go anywhere unless Mary can go with them. Mary is the center of attention at home and her parents can hardly let her out of their sight. They have her sleep in their room because they do not want her too far away from them. The mother said that the father is critical of her if Mary hurts herself slightly, saying that she should have watched Mary more closely.

The mother seems almost as protective of Mary as her description of the father but is beginning to feel very tied down. She expresses some resentment about the father's attitudes toward Mary and herself. The mother said she felt the father was losing his interest in her. He was concentrating entirely on the child and giving her all of his attention. The mother was doing everything she could for the child and was really trying to care for her the way the father wanted her to. But no matter what she did, her husband was still critical of her.

She admitted a good deal of dissatisfaction with her own life, too. Before Mary came, the mother had held a fairly responsible job—and her husband had seemed proud of her and interested in what she was able to do. She says that she does not have enough to do now and the responsibilities she does have are not stimulating enough. Because she had come from another State fairly recently, she has few friends and is practically without interests outside her home. Financially she does not need to work but she is thinking of finding a job to occupy at least part of her time. At this point the worker asked, "Is this really why you want to go back to work?"

The mother thought for a moment and came back with, "I really don't know! When I think about it, I know I really have enough to do at home. Ac-

tually I'm busy all the time." The worker asked, "Do you think your husband would have more respect for you if your worked?" The mother looked a little startled; then said, "Maybe so." "Perhaps this is why you feel tied down and resentful of your husband's attitude toward Mary. It must seem to you that he thinks Mary is more important than you are," the worker said. The mother didn't answer but seemed to be busy with her own thoughts.

The worker asked whether she thought children Mary's age really needed their mother's care and whether this responsibility was an important one. The mother nodded her head in agreement.

As the worker and the mother went on discussing young children and the possible causes of Mary's behavior, the mother was able to say that she thought Mary was responding as she was because of the way she and her husband had been handling her; maybe Mary's difficulties went back to the relationship between them. The mother guessed that she, herself, had been holding Mary too close because she was unhappy in her relationships with her husband, and Mary bore the brunt of this. For the first time, the mother seems to be able to look at Mary and her needs as a growing child.

The mother, once having recognized the situation for what it was, could accept responsibility for it and do something about it. At a later interview, the mother reported that she and her husband had talked things over. She had decided not to go back to work. These were important years in her child's life and in the lives of her parents. They were trying to give Mary more opportunities to play with other children. They had invited a neighborhood youngster into the home to play and Mary seemed to get great enjoyment from this. Clearly Mary's problems were not all solved but progress had been made and the way was open for further work with the mother.

Another 3-year-old was referred to the medical social worker by the physician because the mother was concerned about his behavior.

Johnny sucked his thumb, masturbated, and had a speech difficulty. She thought Johnny's difficulties dated back to the time when she had had to return to work because she had separated from his father.

She had had a child prior to her marriage to Johnny's father and had always felt quite guilty about this. "The bottom just dropped out of everything" when she learned she was pregnant and she had never really been quite happy since. The grandmother had always cared for this older child.

After her marriage to Johnny's father, the mother soon found that he would not assume financial responsibility for the family as she thought he should. By the time Johnny was born, they were separated. She returned to her mother's home and was quite miserable because she felt she was a burden. At first she had been getting public assistance but this was stopped when the father had indicated he wanted a reconciliation. The mother, feeling that he had not changed fundamentally, did not wish to go back to him.

The father had not supported them adequately while he was in the home and, since the separation, had given only a small amount toward Johnny's support and then only after she had taken court action. She was resentful and disappointed in her husband and upset because she could not give her children the supervision and companionship she felt they needed. Everything seemed quite hopeless to her.

It is at this point she decided that the only thing she could do was to get a job. Immediately Johnny seemed upset, would not eat, lost weight, and became quite withdrawn. Because she suspected that Johnny was not getting enough attention, she arranged to have an aunt who was fond of him care for him. She thought that his behavior had improved some since this arrangement was made but she still was not entirely satisfied. She did not completely approve of the way he was being handled by the aunt. She felt that neither his aunt nor his grandmother had much understanding of a young child's needs.

Johnny was the only boy on the mother's side of the family and all his adult associates were women. As the only boy, he had received a great deal of extra attention; but not all of this was helpful. Sometimes it took the form of teasing about his being different. The mother was aware of these problems but did not know how she could control them completely.

Because of the undesirable effect this type of social situation was having on the boy and because he needed companionship with children of his own age, the worker suggested that nursery school would be a good experience for him—and the mother agreed. The worker helped the mother make arrangements for Johnny to attend a nursery in one of the settlement houses.

The worker, realizing that nursery school placement would not solve all of Johnny's problems, offered continuing services to the mother. She and the mother would see how Johnny responded to nursery school. If this did not work out satisfactorily, some other arrangements would have to be made. His mother will need sustained casework help in coping with her heavy parental responsibilities alone and in working out some of her own difficulties.

Occasionally, of course, medical social workers find mothers who are faced by situations so difficult that good care for the child is practically impossible for them to attain. For example:

Peter who was doing very poorly was referred to the medical social worker with the suggestion from the physician that if the home situation could not be substantially improved, perhaps the child should

be placed outside the home temporarily so that he could be built up to the place where he might be able to get along. All efforts to help the mother improve the care to her children had failed up to this point.

The mother was a somewhat limited individual who might have been able to manage her home and children satisfactorily under less difficult circumstances, but an interview with the worker showed that she was overwhelmed by her responsibilities. The family's housing was deplorable, which made care of the children very difficult. The mother recognized that Peter was malnourished and poorly cared for but was too discouraged to do much about it. She had a large family of six children and the father was not able to earn enough to support them at a decent level. Her own responsibilities in caring for the children seemed too much for her to handle and she was resentful toward the father for not recognizing this and helping her during his off hours.

She said she actually had had "three babies" to care for during the last few weeks. Peter, the child referred by the doctor was about 6 months old; the 6-year-old child had recently broken his leg so he was in a cast and an 8-year-old girl was so retarded mentally that she was completely helpless. There was no money to pay for even part-time help for the mother.

A recommendation that the retarded child be placed in an institution had been so bitterly opposed by the father that no application had been made. The mother said she thought his attitude was changing. The worker suggested that perhaps things would be easier if Peter were out of the home for a while. The mother agreed that with Peter out of the home, she could start making arrangements for placing the little girl in an institution. Even though she gave the impression of being fond of her children and wanting them with her, she was willing for Peter to go away temporarily. She said that it seemed the best thing to do because she could not give him the care he needed.

The worker was able to arrange through a child-placing agency for Peter to go to a foster home for 3 months where he gained weight rapidly and otherwise made good progress. During this time, the retarded child became ill and died.

The worker encouraged the mother to talk about her feelings about this, realizing that the sense of guilt many parents have about an abnormal child may be intensified when the child dies, particularly if the care the child received was not the best. The mother admitted she felt guilty about the child's death and resentful toward the father. Perhaps if he had permitted the child to go to an institution, she might still be alive. The mother felt that he was blaming her because she didn't do a better job in caring for the children. She had done the best she could under the circumstances. During the interview she said that perhaps it was better that the child had died because she knew the little girl's condition would never have improved.

While Peter was out of the home, the 6-year-old child's cast was removed so he was able to walk again and thus relieve the mother of extra care. After this, the mother was able to make some improvements in her home situation. She found much more satisfactory living quarters which made her housekeeping responsibilities lighter. Shortly thereafter she got a part-time job to supplement the father's income and a relative moved into the home to care for the children while the mother worked. When Peter was finally ready to leave the foster home, the mother was enthusiastic about his returning home. She felt she was now in a position to provide for him. Later clinic attendance showed that he was doing well.

For whatever reason a mother or child is referred to the medical social worker, the worker in the child health clinics is sensitive to the mother's emotional reactions and the ways in which she expresses or disguises her feelings about the child. While working with the mother the worker observes the child's behavior and his relationship to the mother. In all her interviews she is alert to any family and other interpersonal relationships which may affect the child's development.

In the course of her study of the mother, the child, and the family, the medical social worker contributes her knowledge of their social needs to other members of the staff so that these can be taken into account when planning for the care of the child and when carrying out that plan.

Through social casework the medical social worker gives the mother a feeling of acceptance and understanding which may increase her ability to care for the child. She accepts the mother's attitude which may involve hostility or indifference toward her child. She tries to show the mother that she is aware of the many difficulties confronting her and to help her with them. She considers what there is in the mother's marital and family relationships and in the mother, herself, that must be taken into account before the services offered by the clinic can be truly helpful to her and to her child.

In many instances, the medical social worker recognizes that the mother's and child's needs can be met only through the collaboration of other community agencies—and she then uses her knowledge of community resources to help the child and his family.

Some of the developments in the child health centers of the District of Columbia give evidence of the ways in which medical social workers can contribute to child health clinics in providing services to meet the emotional and social needs of mothers and children.

A lawyer and a social worker look at . . .

STANDARDS FOR SPECIALIZED COURTS DEALING WITH CHILDREN

OVER 30 YEARS have passed since the first recommended standards for juvenile courts were adopted jointly by the National Probation Association and the Children's Bureau and issued by the Bureau.[1]

Now, in June 1954, the Children's Bureau is releasing an entirely new statement of standards for courts dealing with children which have been developed by the Bureau, this time in cooperation with both the National Probation and Parole Association and the National Council of Juvenile Court Judges.

Although the juvenile court movement is more than 50 years old, difference of opinion continues to exist on what the function of such a court should be.

Some have felt the court should operate a broad program for the treatment and care of children, similar to programs of public and private welfare agencies. Others would either drastically limit or remove the court's treatment functions.

The new "Standards for Specialized Courts Dealing with Children"[2] attempts to define which treatment functions are appropriate to such courts and which are more appropriate to administrative agencies in the community.

Six major points are made in the 1954 Standards:

1. Due process of law is just as applicable to the procedures in a children's court as it is in any other court. The right of a child to live with his own family and the rights of parents to the care, custody, and control of their children are paramount and these rights should be limited only through due process of law under clearly defined conditions. In observing due process of law, a specialized court dealing with children must keep its procedures flexible, and maintain the basic philosophy of the court which is to treat, not punish, the child.

2. The powers of the court should not be drastically limited or removed. If the court does not have power to dispose of cases, the alternative is to give this power to an administrative tribunal or panel, such as a clinic or a committee of experts and lay citizens. The document rejects use of such alternatives.

3. Unlimited discretion should not be placed in any judicial officer to do as he sees fit with any child. Such discretion is now allowed in many statutes which, in outlining the powers of disposition, permit the judge to "order such other care or treatment as the court may deem best." Statutes should specify a number of types of disposition that may be used by the court and permit flexibility in their use.

4. All parties coming before the court have a right to know the facts on which the court makes its decision. The public has a right to know about the general operation of such a court, but not at the expense of the privacy of the individual child and his family.

5. The parent and child have a right to legal counsel in proceedings in the specialized court and, under certain conditions, counsel for the child or the parents should be appointed by the court.

6. An administrative agency should be able to take some actions with respect to a child placed in its custody without recourse to further court order. Commitment, for example, is not now clearly defined in some statutes as to what rights the parents keep, to what extent their rights are limited and placed in an administrative agency, and what power is still held by the court. The standards define these terms more precisely to set out the rights, duties, and responsibilities of all parties to an action involving a child, including the child himself, his parents, the agency, and the court.

"Standards" was developed under the direction of William H. Sheridan, Consultant on Juvenile Delinquency to the Children's Bureau. The task of collecting and organizing background source materials, preparing initial drafts, and assisting in later revisions was entrusted to Alan Keith-Lucas, Associate Professor, School of Social Work, University of North Carolina. Substantial contributions to the evolution of the concepts and procedures suggested in this document and to its preparation were made by Herbert Wilton Beaser, formerly Chief, Children's Bureau Branch, Office of the General Counsel, United States Department of Health, Education, and Welfare, now Assistant Counsel, United States Senate Subcommittee Investigating Juvenile Delinquency, and by Sol Rubin, Legal Consultant, and by Will C. Turnbladh, Executive Director, of the National Probation and Parole Association.

What the new principles may mean to the 2 professions most immediately concerned with the operations of juvenile courts—lawyers and social workers—is discussed in the papers which follow.

A LEGAL VIEW

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SOME READERS may find a major point of interest in the amount of water which has flowed under the bridge since 1923 when the Children's Bureau issued its initial Bulletin on *Juvenile Court Standards*. Others may focus attention on the bridge itself. This bridge, of course, is the one designed to span the social distance between the fields occupied respectively by social workers and lawyers.

A comparison of the simple quantity of the water in 1923 and in 1954 as such is not presently pertinent. Our concern is with more complex matters: content and direction. The 1923 pamphlet was prepared under the auspices of a Committee of distinguished experts representing the United States Children's Bureau and the National Probation Association. The 1954 booklet on the other hand was produced by a small team of experts, and later examined critically by a larger group. "This group of about 30 persons included judges, probation officers, child welfare officials and others representing the fields of law and social work. In addition, the draft was distributed to about 150 persons throughout the country representing the same fields."

One who reads the two pamphlets in terms of content will note that by comparison the former, today, seems both oracular and thin. It is oracular because the standards are promulgated and the reader is asked to accept them as authoritative on the faith of the proponents.

The latter pamphlet recognizes impliedly the force behind the principle long familiar to lawyers that "the law is unknown to him who knoweth not the reason thereof." It gives reasons. It enables the reader to debate the points in his own mind with the benefit of some of the material available to the writers. Thus, the new volume should make headway by virtue of its own reasonableness.

Again by comparison, the 1923 collection of materials today seems thin. One may liken it to a two-dimensional picture. It gives the reader the rules. To the reader who is already an expert this is perhaps all that is necessary. To the nonexpert, the person who is to be informed, whose intelligent support of the juvenile court movement is sought, it offers what we may describe as an expert's shorthand. The 1954 volume gives us a picture not only of rules, but more of a three-dimensional juvenile court. We see more clearly the staff and the community functioning, each staff member in his own office, and at the same time in his contacts with others within and without the court. 1954 is a far more human document.

Some of us would like to be around in 1984 in order to have a glimpse of the publication to be issued in that year. No doubt some future reviewer will consider the present material as merely a report of progress.

As examples of these differences in content, it is possible to comment briefly on two items. In the 1923 publication, the concise statement is made: "1. There should be available to every community a court equipped to deal with children's cases."

The interested reader is left to explore the significance of that sentence in the 10 pages of the report or elsewhere.

In 1954, the first item on the reader's agenda is an explanatory section entitled the "Philosophy of the Court." The words "individualized" or "specialized" are used. They show us at once that whatever mental picture we may have of an orthodox court we should not allow ourselves to apply it automatically to the present setup. Here is something special.

Again in 1923, the material on "Probation and Supervision" includes a paragraph on the minimum qualifications of probation officers. This paragraph is a little over four lines long. In 1954, the additional space devoted to probation work suggests that our knowledge on the subject has increased. References are made in footnotes to other material not in existence in 1923. Consideration is given to the method of selection, responsibility, a program for continuing education of probation officers. A reference to "civil service or merit system rights as to tenure, salary, promotions, bonus, *etc.*" indicates that these workers as well as the children for whom the court is established deserve consideration.

On the matter of direction, the 1954 publication is addressed to a wider circle of persons including those who should be interested. Here the pamphlet makes a most significant contribution in the field of social engineering, or, if you will, bridge building.

Between the fields occupied respectively by persons trained according to the disciplines of social work and law there is an interstitial gap. As civilization becomes constantly more complex it is easy for each group specializing in its own field to learn more and more about less and less. No one is so imaginative as to assume that eventually each of us will know everything about nothing. But the only safeguards which will insure that we do not drift into that form of isolationist catastrophe are dependent upon our intelligent efforts to bridge the gap. At present, the legal aid society is one bridge anchored in the field of law and gradually making its way toward social work. The juvenile court, by and large, may be considered as a bridge originating in the field of social work and moving steadily, if not too rapidly, toward an accord with law.

The present booklet chronicles not only the progress made but some of the obstacles which are encountered by proponents of accord and which must be surmounted. A few of these may be mentioned in passing: the lack of a vocabulary intelligible to both groups at once; the mental blocks arising from differences in educational discipline; the understandable conservatism of vested interests.

As far as vocabulary is concerned, it is clear that each profession normally employs a shorthand of special words, phrases used with special significance, key concepts. A stranger encountering these words, phrases, and concepts and not realizing the setting in which they are used is likely to attach to them his own meanings, and to draw therefrom inferences perhaps quite afield from those intended by the users. The 1954 booklet at the very outset is faced with a decision as to one of these words. Shall it call the court a "socialized" court, after the usage of former Dean Pound, or something else? To persons trained according to the social work discipline, "socialized court" is in the nature of a proprietary label like "made in America." They point to it with pride. To the lawyer who is not familiar with the special usage, the phrase conjures up more or less vague visions of foreign ideologies, socialized medicine, and the like. Consequently the term "specialized" or "individualized" court which is equally accurate is far less provocative. It does not need to be explained. Again to the lawyer, phrases like "legal custody," "guardianship of the person," "residual parental rights and responsibilities," "probation for children," "protective supervision," "aftercare supervision," "detention and shelter care" have a general rather than a specific and distinctive significance. Comparatively few of these terms have been defined by the opinions of judges of appellate courts and for the lawyer it is the judicial opinion that represents authority.

The pamphlet spells the specialized meaning out in detail. One can hope that many cases involving the functioning of juvenile courts may in the future be taken up on appeal. By this process not only will the law thereby be clarified but the definition here enunciated will receive attention and, one may hope, legal sanction.

The bulletin does not contain specific evidences of differences in educational discipline and of the conservatism of vested interests but it is refreshing to read toward the end the emphasis on the need for removing the occasional "open distrust of the court by lawyers." It is not likely that any such lack of

confidence will eliminate itself. The program for removing it, one suggests, should be preventive as well as remedial. Schools of social work offer courses in law. Schools of law should be encouraged to offer courses in social work. There, *in limine*, many grounds for possible disagreement may be ironed out.

Everyone should welcome this book. It brings the problem out in the open where we can all take a look at it. It inspires us by the record of achievement in a short 30 years. It challenges us to see if the next 30 can be made equally productive.

A SOCIAL WORK VIEW

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HISTORICALLY *Standards for Specialized Courts Dealing With Children* is long overdue. It is one of the most important publications in the field since the first juvenile court act itself.

Few social workers will be able to examine *Standards* without a sense of excitement and satisfaction. It puts together the best in experience, knowledge, and understanding, for a clear blueprint of the specialized court with its great helping potential for the thousands of children who come within its jurisdiction.

This, however, is not the sole contribution of *Standards*. Out of the very process of setting down principles which reflect advances made in the juvenile court field and increased knowledge of child care, there has been created, perhaps unexpectedly, an integration of what have often been considered two separate and incompatible entities: the administration of the law, and the giving of social services to the troubled child and his family. This integration has been achieved, in part, by clarifying the essential nature of the court as an instrument of nonpunitive justice, individualizing the situation of those who come before it and protecting the legal rights of the persons involved in that situation.

Additionally, however, in spelling out the details of how this kind of court might best operate, its processes have been conceived as requiring the provision of a helping service directed toward full and responsible participation by those who serve as well as by those who are served. A blueprint which achieves so much is hardly less than magnificent and the significance of *Standards* will become increasingly apparent over succeeding years.

Despite the foregoing, there will be some persons who will not be immediately pleased with the whole of *Standards*, or willing to accept them. Those with legal training will be quick to identify with and approve the emphasis on the protection of the individual's legal and constitutional rights which are so often overlooked in juvenile court practices. The social worker will be as quick to identify with the parts of the work directed toward meeting the needs of children and their families which likewise have been often overlooked. Paradoxically, the former may have difficulty in assenting to, for example, the limitation on the powers of disposition accorded the court. The limitation, nevertheless, embodies the substance of the protection initially approved. Conversely the social worker, who will welcome the clarity of the proposed principles of disposition, may have some difficulty—in his haste to get on with the important task of helping the child in trouble—in understanding the insistent emphasis on due process of law.

Why the paradox should exist in each instance is worthy of some consideration for a careful perusal of *Standards* reveals that the protection of legal rights is viewed as a prerequisite for meeting human needs, and the meeting of human needs is seen as a prerequisite for the protection of legal rights. What may initially stand in the way of such recognition by readers of *Standards* is, perhaps, a deeply human problem shared in common despite the differences in professional backgrounds. That problem is concerned with the use of one's own self when addressed to any complex matter involving the substance and nature of another person.

The problem of judges, for example, who impose their own personal and arbitrary religious and moral ideas on those who appear before them is well known to social workers and court practitioners. Interestingly enough, while such impositions can be held to be as much of a violation of the client's rights as the failure to provide any constitutional guarantees, there is little, if any, legal structure or even training designed to prevent such violations. The law simply

assumes judges will not so act. While the law always stresses individualization, accepts the concept that there is room in society for all kinds of differences in behavior, and insists that it must be shown beyond a reasonable doubt that the person charged has actually violated the law, the law itself cannot prevent the exercise of personal ideals or attitudes of a judge, if the latter chooses to impose them.

The child is a particularly satisfying object for such projection. Thus, those who readily accept the need for careful protection of legal rights, from arrest to the court hearing, are easily tempted to overlook such elements when it comes time to decide what is best done in the interests of the child. By limiting the disposition powers of the court, *Standards* offers a continuing protection that can stand in the way of such projection.

On the other hand, social workers, professionally disciplined with respect to the use of themselves in the helping task, are accustomed to thinking of this discipline as a guarantee of the protection of the client. This is not necessarily equated, however, with liberty in its political or legal sense.[3] Nevertheless, in their concern with the needs of the child or his family, social workers become impatient with legal safeguards, such as rules of evidence, evolved from hundreds of years of legal experience and history and which still represent the most universal and applicable form of protection yet devised.

There is no reason, however, why the social worker, accustomed to working within the limitations and regulations of the social agency, cannot accept the legal limitations which constitute the framework of the court. That the task will be easier if *Standards* is followed, cannot be denied, for the court's legal structure and procedures would then be addressed, like the social agency's own policies, toward the fulfillment and achievement of service. Social work's quarrel, if it can be termed that, with due process of law as exemplified in some courts, is not in reality a resistance to the protection of the individual's rights. It is simply in protest against those legal limitations or procedures which bear no dynamic relation to the individual as such. Conversely, those in the court representing the field of law are not really in opposition to a limited and disciplined helping process as an integral part of the court's procedures. Their opposition is only to that kind of helping which ignores the special obligations of the law. If each could see the special nature of the other's discipline, while holding fast to a broader application of his own, encompassing *Standards* as a whole would be an easier task.

Over the past 25 years there has been sharp conflict between those who would see the court as primarily a social agency and those who would limit the juvenile court to a judicial determination of facts with treatment decisions placed in the hands of an administrative agency. The former would minimize the legal or judicial components of the court, while the latter would hold the court's powers to a mere judicial determination of the facts at issue.

Standards presents a firm ground for resolving this tiresome controversy. The point of view held by *Standards* confines the court's functions to conducting hearings and making dispositions in every instance in which the right of a parent or a child may be curtailed by authoritative action. It is with the details of arrests, investigations, hearings, adjudications, and making of dispositions with which *Standards* is largely concerned. It is here where the special genius of the work has merged law and social services into an orderly, purposeful, disciplined helping process demanding the best of each profession. It is here that mutual respect and a willingness to work together must be forged. *Standards* points the way for this working together in order that the real effectiveness of the specialized court dealing with children may be revealed to the advantage of all.

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[1] Juvenile-court standards: report of the committee appointed by the Children's Bureau, August 1921, to formulate juvenile-court standards. Children's Bureau Pub. 121. Washington, D. C.: Government Printing Office, 1923. 10 pp. (out of print).

[2] Standards for specialized courts dealing with children. Children's Bureau Pub. 346. Washington, D. C.: Government Printing Office. 1954. 99 pp. 35 cents.

[3] Keith-Lucas, Alan: The political theory implicit in social casework theory. *The American Political Science Review* 47: 1076–91. Dec. 1953.

A NEW LIFE SAVING SERVICE FOR CHILDREN IS LAUNCHED

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A POISONING CONTROL PROGRAM, the first of its kind in the United States, is under way in Chicago. Developed by the Illinois Chapter of the American Academy of Pediatrics and approved by the Chicago Medical Society, this program is designed primarily to aid physicians in treating children who have accidentally swallowed household substances that may be poisonous and to prevent future poisoning cases. Already, similar programs are being considered in a number of other cities.

A Serious Health Hazard

The National Safety Council has estimated that there are 187,500 cases annually of accidental poisoning in the home, and that 1,250 of these result in death. This is of particular interest to pediatricians because the individuals most affected are infants and children who swallow cleaning fluids, fuel oil, insecticides, drugs and other substances found around the kitchen, the basement, the garage, and the yard. This is a hazard that is increasing rather than decreasing. The scientific and technological advances that bring new vaccines and antibiotics to conquer disease also bring new synthetic insecticides, weed killers, rat poisons, detergents, home permanent wave solutions, and other dangerous substances in reach of almost every infant and child.

In this country about 400 children under 5 years of age are known to die each year from accidental poisoning in the home. This represents a death rate 4 times as high as the British rate for this cause and this age group. Death rates in the United States and in Great Britain are generally comparable and such a large difference for one specific rate calls for careful examination. For this reason the deaths from accidental poisoning of children under 5 years of age that occurred during 1949 and 1950 have been analyzed in considerable detail.

A report on this subject[1] by Dr. Katherine Bain of the United States Children's Bureau shows that foodstuffs are no longer a common source of poisoning. Only 8 deaths due to this cause occurred in the 2 years under investigation, and these were attributed to such substances as wild berries, toad stools, and green pecans. Slightly less than a third of the deaths were due to drugs or medications. A little more than a third were due to general household items such as bleaching agents, furniture polish, and moth balls. A quarter were due to petroleum products, principally kerosene. Five percent of the deaths due to poisoning in the home were unclassifiable because of insufficient data on the death certificates.

Some of the drug poisoning in small children is due to over dosing, but a great deal of it is like any other household poisoning—the child simply swallows something he has found. The most common drug killer in this age group is aspirin. The next most frequently lethal drugs are the barbiturates.

The American people spend a great deal of money on medicines. In 1951 the public spent about three-fourths of a billion dollars on prescriptions and a full billion dollars on packaged medication, of which $135 million went for aspirin and analgesics.[2] This means that practically every household has some type of pill or medicine around. Too frequently adults assume that these drugs are harmless and leave them where young children can easily reach them.

Kerosene, especially among rural and low income families, is another health hazard. Each year there are more than 100 deaths from this cause among children under 5 years of age. This is one of the major factors in the high United States rate compared with the British. In the United States the nonwhite rate for this cause is about 6 times the white rate.

Even when kerosene is considered as a separate

class the largest number of deaths occur in the category of general household items. Caustic substances, such as lye and ammonia, cause an appreciable number of deaths each year; rat poisons and fly sprays continue to be hazards to young life, and some of the newer insecticides and pesticides are appearing in the list, such as DDT, parathion, and its very toxic derivatives. But the list also includes a great variety of items, such as permanent wave solution, shampoo, lighter fluid, rubbing solution, bleaching agent, antifreeze, moth balls, furniture polish, and other common household substances.

The fact that 5 percent of deaths from poisoning cannot be classified because of insufficient data on the death certificates shows that physicians as well as parents need education in this problem. An autopsy should always be obtained on an obscure case since an accurate diagnosis is necessary if similar accidents are to be prevented.

Childhood deaths from poisoning occur disproportionately often in 12 Southern States—Alabama, Arkansas, Florida, Georgia, Louisiana, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, and Virginia. The rate for these States as a group is 4.09 per 100,000 population as against 2.00 for the remainder of the country. For the barbiturates and aspirin there is little regional difference. But for corrosives and arsenic the rate for these southern States is 6 times that for the rest of the country, and the rate for petroleum products (principally kerosene) is 4 times as high there as elsewhere. Lead poisoning is more common outside the South. This may reflect a regional difference in the use of paint, or it may reffect the better diagnostic facilities in urban centers.

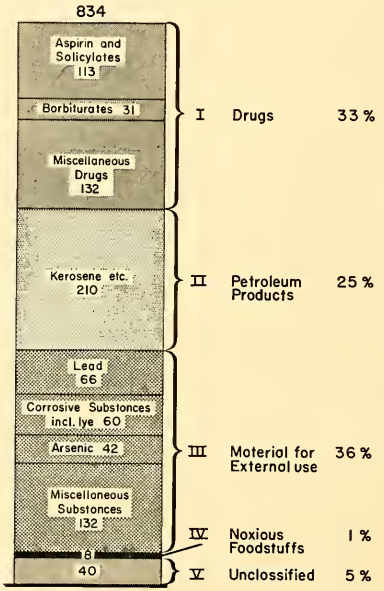
Treatment Problems

Relatively little is known about poisons and the specific treatment of poisons, although the average home is loaded with potentially dangerous items. It is impossible for the practicing physician to keep posted on the identity of the toxic constituents involved in the large number of household items that are poisoning hazards. And even when the substance has been identified, there may be differences of opinion as to what is the best treatment.

When a child has swallowed some household substance, the label on the package may not tell the physician what he needs to know. The Federal Food, Drug, and Cosmetic Act makes specific requirements with regard to the appropriate labeling of each of these kinds of substance. For example, drugs, to be properly labeled, must bear adequate directions for use and warnings or precautions against misuse. The Caustic Poison Act requires that 12 designated caustics and corrosives when present in specific amounts in consumer-sized packages shall be labeled with the identity of the substance, the word "poison," and directions for emergency treatment, including an antidote statement, in case of misuse. But this leaves a wide area of household materials untouched. There are many hazardous chemicals to which the householder is exposed which are not covered by labeling laws. For example, silver polish may contain cyanide, or a cleaning fluid, carbon tetrachloride.

The number of potential poisons and the related facilities for clinical and chemical analysis are so complicated and extensive that it is not feasible even for a large hospital to have its own comprehensive toxicological laboratory. Moreover, there are very few poisonous substances for which an analysis can be made rapidly enough to be of help in immediate treatment. In most instances it requires at least 3 to 4 hours to get results of the analysis. Certain

SUBSTANCES RESPONSIBLE FOR DEATH FROM ACCIDENTAL POISONING OF CHILDREN UNDER 5 YEARS: U.S. 1949–50



types of analyses, such as that for lead poisoning, require special facilities that are not available in most cities.

Even when the specific poison is known, there is much to be learned about the most effective methods of treatment. For instance, there is a difference of opinion among competent physicians as to whether or not gastric lavage is advisable for such common toxic substances as lye or kerosene. Many physicians believe that lavage should not be used when either of these 2 substances has actually been swallowed. Others, including the author, feel that if done carefully, with a well lubricated tube, within 30 to 60 minutes after ingestion, lavage may be life saving.

There is an acute need for a central clearing house of information on poisons, that can be immediately available to physicians and hospital emergency rooms. But an entirely comprehensive list of poisons would be an extensive job and require a great deal of time and money, and would have to be a nationwide service.

The Chicago Trial Program

Before attempting to set up such a program on a permanent or citywide basis, the Committee on the Chicago Center for the Control of Accidental Poisoning in Children, of the Illinois Academy of Pediatrics, conducted a trial program which lasted 3½ months and covered 6 hospitals. In this undertaking, the Committee had the backing of Chicago's five medical schools, the city Board of Health, and the State Toxicological Laboratory.

Participating hospitals reported all cases of accidental poisoning in children treated in their emergency rooms to the Chicago Board of Health. A uniform reporting form was developed by the Committee for this purpose. Reports were analyzed and summarized by the Board of Health, with the guidance of the Committee members. The summaries showed the total number and types of cases treated, the number of deaths, and the comparative effectiveness of various treatment procedures. Analyses were made to reveal any significant increase or decrease in the incidence of poisoning or its virulence.

A manual summarizing the latest methods for treating various types of poisoning, together with cross references to published lists on the contents of thousands of household substances, was developed and is being kept current by additions and revisions. This and other information which is not in form for general distribution was made available to the participating hospitals.

Before Chicago's poisoning control program was even tested, it had behind it the support of the city's five medical schools, the State Toxicological Laboratory, and the City Board of Health, as well as the counsel of such national groups as the American Medical Association, the National Safety Council, and the Federal Food and Drug Administration. This small patient is having his stomach emptied by a resident physician on the staff of the Children's Memorial Hospital, one of the six test hospitals.

One hundred and fifty-five children were treated in the 6 cooperating hospitals during the trial period. These children had swallowed a variety of substances, including rat poison, turpentine, kerosene, insecticides, liniment, bleaches, and lye.

None of these cases proved fatal. This fact is not statistically significant since there is no adequate basis for comparison. But the services were felt to be beneficial and recommendations were made to put the program on a regular operating basis and to make it available to other hospitals and physicians.

In the Chicago program, there were 20 cases of poisoning by fuel oils. This is not as large a proportion of the poisoning cases as the national mortality rates would lead one to expect, but it is a higher proportion than in the rate for the United States exclusive of the 12 southern States. The remaining cases were equally divided between medications and general housekeeping materials. But in this grouping liniment, for example, is included under medications. If materials intended for external use had been classified under household items, as in the national survey, the Chicago experiment would show

an even larger proportion of poisoning cases due to general household items than do the national figures.

Prevention Is Important

A facility for the control of poisoning, primarily in children, should necessarily take some responsibility for prevention as well as treatment. Better labeling alone will not meet this problem, especially in the case of small children. The public, and in particular parents, need special instruction in regard to poisoning prevention. Before this can be done efficiently, more information must be gathered on the circumstances surrounding each accidental poisoning.

From the beginning of the Chicago trial program this preventive feature was stressed. Board of Health personnel made home visits and other follow-up contact measures, wherever indicated. Altogether, 55 home visits and 32 telephone followups were made. Thirty-eight of the home visits and 15 of the telephone calls led to corrective measures likely to prevent similar accidents from recurring.

In one case, for example, a boy under 2 years of age was being cared for in his parents' absence by a pregnant aunt who lived in the upstairs apartment of the patient's building. The sole source of heat in this apartment was an old kerosene stove which leaked. The drippings were caught in an ordinary drinking glass placed on the floor. While the aunt's back was momentarily turned the child who was playing on the floor drank some of the kerosene.

Immediately the boy began to cough violently and vomited a little. The parents had no family physician. They brought the child directly to the emergency room of the County Hospital. Here his stomach was emptied and washed with tap water within a half hour of the time he had swallowed the kerosene. The boy seemed all right, but because of prior experience with kerosene poisoning the hospital authorities decided that he should be hospitalized and treated with penicillin, streptomycin, and steam inhalations. In spite of this he developed early signs of pneumonia. Oxygen was added to his treatment regime. Within 4 days he was well enough to be discharged and followed later in the clinic.

When this case was reported to the Chicago Board of Health, a nurse made a followup visit to the home. The stove was still leaking kerosene and there was broken glass on the floor. Furniture polish, shoe polish, bleach, and other household items were stored in a box on the floor of the living room. The family was strongly urged to place these items on shelves out of reach of the child, and to have the stove repaired. In a later telephone check it was learned that the recommended precautions had been taken.

In another case, a 15-month-old child had swallowed a cresolic disinfectant. He was successfully treated but at the home followup he was found chewing paint from the window sill. The danger in this practice was explained to the mother and steps were taken to prevent further paint chewing.

Spreading the Idea

Both the American Academy of Pediatrics and the American Medical Association have been interested in the problem of accidental poisoning for several years. The Academy of Pediatrics through its Accident Prevention Committee, with Dr. George Wheatley as Chairman, has encouraged pediatricians to include accident prevention activities of all types in their daily medical practice. The encouragement and stimulation of this committee was one of the major factors in helping get the Chicago program started. Moreover, they are taking an active role in helping implement the interest and plans for similar projects of physicians and local chapters in Boston, Cincinnati, New York, Washington, D. C., and other cities. It is felt that the central office of the

As important an ingredient in Chicago's poisoning control program as treatment is the preventive work done by the city Board of Health which sends workers into homes to advise parents on safety measures. While this mother's back is turned, a visiting public health nurse stops the small daughter in the act of reaching for a can of drain cleaner which is a lye compound. Parents are made alert to many apparent trifles which can, and do, bring tragic consequences.

Academy of Pediatrics in Evanston, Ill., may well serve as a clearing point for various local poisoning control centers throughout this country as well as other countries that are members of the American Academy. This would help promote a more thorough and widespread dissemination of information on the subject.

The Council on Pharmacy and Chemistry of the American Medical Association through their Committee on Pesticides has been interested in the problem of poisoning from insecticides, rodenticides, herbicides and related materials for several years. The secretary of this committee is also a member of the Chicago Poisoning Control Program. As a result of the general interest in the subject of poisoning on the part of the American Medical Association, the American Academy of Pediatrics, and others, and encouraged by the Chicago Program, the American Medical Association has under consideration the formation of an overall committee on toxicology. Such a committee could gather information on toxic reactions to new drugs, or new toxic reactions to older drugs and proprietary remedies, as well as on new household products, pesticides, and related substances. It could receive and collate reports on poisoning in children funneled through Academy of Pediatrics channels. In addition it could get reports on other toxic materials sent in by physicians in industry and related nonpediatric fields.

In the long run, poisoning prevention depends on knowledge. We must have the information as to what is contained in various household substances. We must also have the information that can only come from home visits or other careful followup as to the various practices and living conditions that put these substances within the reach of children. And we must pass this information on to the public. A poisoning control center should attempt to get this public health information into the home at the same time that it is providing physicians and hospital emergency rooms with more technical knowledge regarding analysis and treatment.

[1] Bain, Katherine, M. D.: Death due to accidental poisoning in young children, to appear in *Journal of Pediatrics* June 1954.

[2] Olsen, P. C.: Three year report on 222 drug store product lines. *Drug Topics* 96: 1, Aug. 11, 1952.

INDUSTRIES HELP IN SAFEGUARDING CHILDREN

Accidents kill and cripple more children in the United States of America than all the infectious diseases of childhood put together. Motor vehicles are the greatest single cause among children over 1 year of age. For infants and preschool children, accident risks are greatest in the home.

Increasingly, preventive measures are challenging the ingenuity of many groups working with children, stimulated greatly by the American Academy of Pediatrics' Committee on Accident Prevention. Industries are joining forces with public health and other authorities to put their customers on guard against possible dangers, and to aid health workers reduce the toll of child life.

The Chemical Manufacturing Association and the Chemical Specialties Manufacturing Association have worked with the New York State and City health departments on a new chapter to that State's Sanitary Code. This will call for more informative labeling of containers of hazardous substances, both to motivate parents to keep toxic household substances out of reach of children, and to inform physicians of ingredients that may have been ingested.

Burns, explosions, and fires are a frequent cause of home-accident deaths among young children, especially those in rural areas. The American Petroleum Institute has made a film explaining, in simple ways, the explosive properties of home and tractor fuel and power oils. Copies of this film are made available, on free loan, to agriculture educational centers.

What seemed, in the late summer, 1953, to be an epidemic of child deaths due to suffocation in discarded refrigerators has moved the Refrigeration Trade Association of America to step up its educational efforts of prevention. This Association has been working with local groups in drawing up codes covering the disposal or care of unused iceboxes. Too, it has been urging its 8,000 members to include, as part of their normal service in installing any refrigerator, an offer to remove doors from replaced units.

The American Gas Association is working on the hazards of gas in domestic use. It has recommended that all gas utility companies adopt and publicize the policy of providing free investigation of all faulty operating gas appliances and free inspection of newly installed gas appliances, with charges only when actual maintenance and repair are required.

Two technical subcommittees of the American Standards Association have been set up recently to study the flammability of children's clothing and the labeling of lead-base paints.

The list of private and public efforts to combat high accident rates among children is long. Cooperating in many of these activities is the Home Accident Prevention Unit of the Division of Sanitation, U. S. Public Health Service, formed 5 years ago. Recently, an informal committee, on which the Children's Bureau has representation, was created by the Unit from among the constituents of the Department of Health, Education, and Welfare. For the immediate future, this committee will focus its attention on all aspects of child safety.

IN THE JOURNALS

Why Babies Cry

An amusing statement that should arouse comment among almost any people who have been privileged to observe babies closely is Saul Rosensweig's "Babies Are Taught to Cry: a hypothesis," in the January 1954 issue of MENTAL HYGIENE. Whether or not readers find his arguments plausible, they will almost without exception give a nod of wry acceptance to his remark that "One must not, however, expect that the baby who has been understood . . . will never cry."

T. and A.? . . . That is the question

Dr. Joseph A. Johnston and Dr. Thomas W. Watkins report in the JOURNAL OF PEDIATRICS for February 1954, on an interesting followup study of 598 cases at Henry Ford Hospital in Detroit in which tonsils and adenoids had been removed. They bring out the importance of a period of observation before a decision to remove is reached, a period long enough to make sure that other causes can be ruled out.

"Stretching the Nurse"

"Never consider any of the duties of your department beneath your dignity as a department head. . . . We are going to have human relations, so they might as well be good." How to go about making relations democratic and profitable between hospital nurses and the aides, volunteers, practical nurses, clerks and others who free nurses for their planning, teaching, and supervising duties is the subject of "Stretching the Nurse," a piece in HOSPITALS for March 1954, by Ruth Sleeper, Director of the School of Nursing and Nursing Service at Massachusetts General Hospital in Boston.

"When will he be 5?"

People whose children's birthdays come at the "wrong" time of year are often irritated over what seem arbitrary rules about school entrance. They and others who have wondered about such questions as the length of the kindergarten day, how many children are desirable per teacher, and whether mothers should stay with their children the first day will be interested in an opinion poll carried on by the Kindergarten Committee of the Association for Childhood Education International, and reported in the March 1954 issue of CHILDHOOD EDUCATION. Neith Headley of the University of Minnesota tells what 180 kindergarten teachers, most of them with 5 or more years of teaching experience, believe. Their intimate acquaintance with young children has led them to the conclusion that it is desirable for a child to be within a month of 5 when he starts to kindergarten; that a 2½- or 3-hour session is more desirable than a 2-hour one; that a teacher handling 25 5-year olds should have an assistant; and that children who have not had nursery school experience should visit the kindergarten with their mothers before it's time for them to enter. Among the other items on which opinions were given are such details as size of kindergarten room, how to report to parents, and readiness tests.

Are their basic rights being denied?

"Home Problems and Family Care of the Mongoloid Child," by Rudolf P. Hormuth, is one of several articles in a symposium on mongolism in the QUARTERLY REVIEW OF PEDIATRICS, November 1953.

Mr. Hormuth, who is Assistant Executive Director of the Association for the Help of Retarded Children, wants professional people to take a sharp look at their practices with regard to mongoloid children. Those who are "most verbal" in the defense of children's rights, he says, "maintain a deadly silence" when these same rights are denied the mongoloid child. Parents are actually encouraged to reject these children, though placement is often so expensive and difficult that the child winds up back in a home and community wretchedly unprepared to accept him.

An objection frequently raised to keeping a mongoloid child at home is the effect on normal brothers and sisters. But Mr. Hormuth's experience is that "very young children show little or no prejudice," and that "if the parents show no prejudice, few of the normal siblings will." When a normal child feels he is being of help to his mongoloid sibling, the author says, "there are no ill effects."

Why do children suck their thumbs?

This perennial puzzler to parents, as well as to pediatricians and psychologists, was studied by Leon J. Yarrow at the Child Research Council in Denver and reported in the March 1954 issue of the JOURNAL OF GENETIC PSYCHOLOGY. Dr. Yarrow tried to isolate some of the factors associated with thumbsucking. One that seemed to be positively related to thumbsucking in late childhood was the amount of opportunity for sucking during feeding in early infancy. The author emphasizes that there are probably a variety of conditions underlying thumbsucking, and not any single cause. The title of the study: "The Relationship Between Nutritive Sucking Experiences in Infancy and Non-nutritive Sucking in Childhood."

What makes people change?

People who try to get other people to accept and put in practice new ideas need to keep in touch with what research has to tell them. In "Changing Family Health Patterns: a review of recent research" (JOURNAL OF HOME ECONOMICS, January 1954), William Griffiths of the University of California cites a variety of studies dealing with health, nutrition, and food habits. The vast importance of considering how people in different cultural settings perceive their needs, and the fact that "many individuals feel most comfortable in carrying over into a new generation the traditional family practices" are effectively illustrated. Evaluation of efforts is imperative, if results are not to be negligible.

A unique population

Joseph W. Eaton and Albert J. Mayer, in HUMAN BIOLOGY for September 1953, discuss "The Social Biology of Very High Fertility among the Hutterites." They show that since coming to this continent about 75 years ago, the Hutterites have set what is probably a world record for population growth, increasing over 4 percent per year or doubling their numbers each 16 years.

Three reasons are found: (*a*) the availability of medical facilities, (*b*) the complete proscription of birth control, and (*c*) the group's religious emphasis on mutual aid. Considered separately, no one of these conditions is unique to the Hutterites, but "what is unique is the combination of the three factors." Personal costs are great, of course, especially to Hutterite women. Despite maternity care, a higher proportion of these women than in other civilized groups fail to live beyond 55 years of age.

This article gives no hint of whether the Hutterites actually have (as claimed in 1951) much less mental illness than their neighbors. The answer to that question is promised in a book due this year.

Telling people is not enough

How to be sure people read and absorb new information intended to be of use to them is the subject of a study on "Pretesting a Pamphlet for Reader Comprehension," by Marie Ford and Ruth Stief, of the Minnesota State Department of Health. Their plan of action involved finding out whether mothers of school children would read a pamphlet their children brought home to them on the nutritional importance of milk and would at the next PTA meeting answer a questionnaire about what they had read. Would their presentation of facts about milk impress people who think it's only for babies and children or that it's fattening?

Even though the material was worked over by means of a simplification of the Flesch reading ease formula some mothers didn't read it. But they contributed their bit, at the meeting, by serving as a control group. In the end, the authors were encouraged to believe it would pay to put *more* information, based on readers' known needs, into readable and attractive—but still accurate—form. The study is reported in the January 1954 issue of the JOURNAL OF THE AMERICAN DIETETIC ASSOCIATION.

Choosing a camp

Alethea T. Beckhard, Director of the Camping Division of the Girl Scouts, and Chairman of the Field Services Committee of the American Camping Association, doesn't believe that there's "a certain age" at which a child should go to camp. But she points out in the Spring 1954 issue of CHILD STUDY, that at one age one camp may be right, at another age a quite different one. "A great display of equipment" may cover up a lack of good program. Variety of activities should be given as careful an inspection as the physical setup. Workers with children will be glad the author stresses the value of family-size groups of 6 or 8, and relieved, perhaps, to know that she favors breadth of interest in the counselors who live with these groups, rather than that each should be bound up in one special hobby.

Community action

In the March 1954 AMERICAN JOURNAL OF PUBLIC HEALTH are gathered together a great many of the words of wisdom spoken at the 81st annual meeting of the APHA. Those who are interested in involving the consumers of public health in its further development, but who did not get to the 1953 meeting will have a sense of having participated when they read 4 papers presented by Dr. Harold M. Erickson, Dr. Richard W. Poston, Dr. Earl Lomon Koos, and Dr. John Porterfield. Dr. Erickson describes two instances of community action in Oregon; Dr. Poston tells how a community can take a look at its total needs and activities, illustrating his points by Montana and Washington experiences. Five ways a community may react to its health needs are pointed out by Dr. Koos, who makes it clear that reaction—positive or negative—depends upon what "health" means to people, how it is valued in comparison with other "symbols of civic pride," and how close people in the community can get together in their thinking.

Dr. Porterfield draws out practical applications from the 3 papers, emphasizing teamwork with the social scientist, and 2-way communication with the people who are both the users of what public health provides, and the payers of the bill. "Public health is not something which can be found in the health department, rather it is in the neighborhoods where people live," as Dr. Poston says.

Blind babies' foremost needs

The natural tendency of parents whose infants suffer from retrolental fibroplasia is to concentrate more on their child's blindness than on his whole-child needs. Because of this it is highly desirable that such sound practical knowledge as Dr. Arnold Gesell gives in THE FIELD OF VISION for December 15, 1953 be interpreted to parents. In "Development of the Infant with Retrolental Fibroplastic Blindness" Dr. Gesell differentiates clearly between these cases and uncomplicated prematurity, in which appraisals of behavior patterns are made in terms of the corrections necessary to indicate the infant's true age.

In the case of the blind premature baby, his total development may be held back if his parents are not early made aware of what a great deal they can and should do during the very first year of life. It is of basic importance, for example, that they stimulate the baby's postural behavior from the beginning.

A wide range of valuable experience is suggested: having a roomy tray for his high chair; many objects for him to play with that he can safely mouth; not letting him lie on his back too much; leaving his legs and arms bare—his sense of touch "embraces the whole skin," says Dr. Gesell. Keep him venturing. "Teaching" him is unnecessary—he will develop if he is plentifully supplied with things and people that encourage him always to reach out, bodily and mentally, beyond himself.

Vandalism can be minimized

A continuous program of constructive citizenship will do the job, say William A. Bristow and Alex H. Lazes of the New York City Board of Education. The authors' claim in THE NATION'S SCHOOLS for April 1954, is bolstered by accounts of what has helped in various cities. They rely on activities that contribute to understanding of what is being attempted, like letting students take part in making school regulations, having them help in decorating the building—their parents, too, sometimes. Sponsoring outdoor school events, providing discussion groups for parents, and involving the student council in planning are other "minimizers."

"The discipline most needed today," the authors suggest, "is that of identification with a group, the assumption of responsibility, and the desire to help find solutions to problems."

A private foundation gives a Department of Health a chance to help a community in . . .

REDESIGNING SCHOOL HEALTH SERVICES

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THE SAN FRANCISCO Community-School Health Education Project, which was in operation from 1947 to 1950, has provided a stimulus toward the development of an integrated health program for school-age children. The project has demonstrated that schools and health departments in metropolitan areas can work together effectively and can develop jointly a more efficient program of services than is possible when each agency works independently.

This project, sponsored jointly by the California State Departments of Education and Public Health, was made possible through a supplementary grant of money which the W. K. Kellogg Foundation made to the State Department of Education for the specific purpose of developing a Community Health Education Project. The responsibility for carrying out the project was shared by the Unified School District, the San Francisco Department of Public Health and the San Francisco State College. The State Department of Public Health assigned a medical officer and a public health nurse to serve in consultant and coordinator capacities.

The results of this study, as they affect education and the classroom teacher, have already been reported.[1] The present report is concerned chiefly with the findings that affect medical and nursing services.

Objectives

The overall purpose of this "Community-School Health Education Project" was to study ways and means by which an effective health education program could be developed with available personnel, time, and budget; and to explore ways by which all persons in and out of school who are interested in, and have a responsibility for, children's health can work together toward improving the health of school-age children.

The San Francisco Project Area

San Francisco, a city of three-quarter million people, has a school population of over 70,000 and more than 2,000 teachers. It was not practical to include all the city schools in this project. The study was limited to an area of San Francisco which represented a cross section of the population and which included an elementary school, a junior high school, and a senior high school, in close proximity.

This provided for continuity of health supervision and health education as the children progressed to the various school levels.

The Central Coordinating Committee

The first step was to organize a Central Committee to provide an administrative framework for bringing problems into focus for discussion, joint planning, and action. The Associate Superintendent of the Unified School District served as chairman for this committee. The membership included administrative staff of the Unified School District; principals from the three selected schools; administrative staff from the Bureaus of Child Hygiene and Public Health Nursing and the Division of Health Education, and the public health physicians and nurses serving the project schools; health education consultants from the San Francisco State College; the medical officer and nurse coordinators lent by the State Department of Public Health; and, during the third year of the project, the chairman of the Health Education Committee of the County Medical Society.

The Central Committee functioned as a planning and deliberative body for policy making. The early meetings were devoted to getting acquainted, learning about the contributions of representative members, and acquiring an understanding of the problems. The reward, after a year of such sharing, was the members' unity of purpose and agreement on objectives and basic philosophy.

The group recognized that while parents have a primary responsibility for their children's health, the community has its responsibility too, and many resources which can contribute; when schools, professional groups and agencies support each other and their services are integrated, the total health program is strengthened.

Approaches to the Problems

One of the first steps was to review and evaluate the current health service activities of school and health department personnel and the existing relationships among staffs working with school children.

In order to accomplish this the physician and nurse coordinators made day-by-day observations of personnel at work; administrative manuals of policies and procedures relating to staff activities were reviewed; conferences were held with administrative and supervisory staff relative to their activities, responsibilities, and relationships, on both the administrative and the staff levels; time studies and job analyses were made; individual pupil health records were reviewed and evaluated; and the forms and methods for interchange of information among staff and between agencies and other professional groups were analyzed.

These studies revealed that the potential contributions of nurses and physicians were not being fully realized because of existing administrative policies and procedures. Coordination of services and channels for interchange of information were neither adequate nor uniform. It was also evident that there was a need to clarify individual and joint responsibilities, as well as to explore better ways of using professional skill and time.

In-service Education

These findings focused attention on the need for a planned intensive in-service education program for all of the staffs concerned in this project. Such a program was organized and geared to meet the needs of the various professional groups, administrators, teachers, nurses, and physicians, respectively and concurrently. Initially these planned in-service education meetings served to orient the entire staff to the changes in concepts, policies, and responsibilities of the individual staff members. As changes in procedures and techniques were developed through the cooperative efforts of the various subcommittees and the Central Committee, the in-service education program provided a means for keeping the entire staff informed so that they could move forward as a team.

A committee of staff members planned an intensive program which included staff meetings and workshops for the nurses and for the physicians, held separately and jointly. Throughout the period of the in-service education program, there was a continuing review of records and evaluation of the program—in terms of progress, areas which needed strengthening, and next steps. This democratic approach encouraged participation of the "grass roots" staff in these meetings, awakened initiative which has been dormant, and did much to stimulate and encourage the team concept.

Other workshops provided for joint participation of staff of the Health Department and the administrative personnel of the Unified School District. These were arranged for the purpose of interagency orientation in regard to the services and contributions each of these agencies provided for school-age children, and exploration of ways by which these services could be better integrated.

Special resource consultants from within San Francisco and the surrounding area were made available periodically for combined (public health, school, and State College) staff workshops on special aspects of the project, including evaluation and problems of working together.

Changes in Policy

One of the first changes in policy governing health services was the elimination of routine examinations in specific grades. Instead, children in need of service because of suspected health problems observed by the teacher or nurse, or sometimes the parent, were given first priority. This released more physician time for careful history and examination of referred children as well as for discussing his findings and recommendations with parents. The role of the school physician was gradually broadened to include health guidance and health education for school staff as well as parents, in relation to individual and group health problems.

Another change in policy was directed to better utilization and integration of private physicians' services. This eliminated much of the waste resulting from duplication of school physician and private physician services.

School Health Service Records

The limitations of space on the medical and nursing school record in use before the project was started required that a code be used to indicate health defects. In addition to being difficult to interpret, the code was inadequate for conveying information needed by the nurse or teacher in followup. Changes in policy permitted the cooperative development of an entirely new medical and nursing record in which the code was eliminated and adequate space provided for recording meaningful pertinent information regarding the child's health problem, the medical findings, and followup recommendations for the parent, the nurse, or the teacher.

At the same time that the new medical and nursing record was set up, a permanent form (Teacher Observation of Pupil's Health Record) was introduced for recording health deviations observed by the teacher and for recording information shared between the teacher and the nurse or physician, or other combination of school staff. Such sharing gave the teacher a better understanding of the child's health problem and her role in the followup recommendations made by either the school physician or the child's private physician. Furthermore, since this record was kept in the classroom and followed the child throughout his school period, each new teacher, at the beginning of each school term, acquired valuable information on each child's health status and her part in the followup.

As the project progressed and the concept of teamwork became better understood and appreciated, the 15 to 20 minutes allowed for medical examinations of referred children proved to be inadequate for obtaining the detailed history which the school physicians felt they needed if they were to understand the impacts in and around the home that had a bearing on the child's health problem.

A subcommittee comprising physicians, nurses, principals, and teachers was appointed to devise a health history form to be filled out by parents which would meet this need. After much deliberation, a form was developed which included information needed by, and of value to, all of the different members of the school staffs. The new form also made it possible to discontinue use of the many separate forms sent by the school to the parents from time to time requesting bits of specific information. This complete health history form, called the "Health Inventory" was submitted to the Central Committee for approval.

Although members of the Central Committee and others expressed skepticism regarding the willingness of parents to cooperate in filling out the form they agreed to use it on a trial sampling in the project elementary school. The sample represented about 60 percent of this school's population, and included the kindergarten, first, third, and sixth grades and participation of over 50 percent of the teacher faculty. A carefully worded letter addressed to parents, interpreting the Health Inventory, was jointly prepared by the staff and signed by the principal. This letter, attached to the Health Inventory, was distributed by the teachers to their pupils to take home for the parent to fill out and return to the school. Within 10 days 89 percent were returned completely filled out; in 3 weeks the percentage rose to 93.

Through the Health Inventory, a fund of very valuable information was secured from the parents on family background, current health practices, the parents' evaluation of the child's physical and emotional health status, and the amount of medical and dental supervision which the child was receiving. Such data, for the first time, were now available and readily accessible to the school staff. This informa

ion provided an excellent device for screening children with health problems and revealed many clues which were helpful in bringing unsuspected health problems to light. Whenever the teacher referred a child to the physician or nurse she always sent the child's "Teacher Observation of Pupil's Health Record" to which the child's Health Inventory was attached. Thus the parent's and the teacher's evaluations provided the health service staff a broader base upon which to make recommendations.

Medical Advisory Committee

Tabulation and analysis of the data recorded on the Health Inventory revealed that during the previous 18 months 77 percent of the children had been seen by private physicians. This pointed up the need to direct efforts toward securing greater private-physician participation in the program. To achieve this end, a representative group of private physicians was invited to serve on an advisory committee.

The active cooperation and participation of the advisory committee brought about better understanding on the part of the medical profession of (1) the current school health program and its objectives, (2) the legal and other responsibilities of schools for pupil's health, (3) the Health and School Departments' roles in the School Health Program, (4) the health problems prevalent among school children, and, most important of all, (5) the private physicians' contribution to the Community-School Health Program. Through joint effort, a form was developed to provide a better channel for the flow of information from the school staff to private physicians and from private physicians to the schools. In addition, the members of this medical advisory committee projected future plans which would provide for orientation of the members of the County Medical Society to the Community-School Health Program.

Integration of Other Community Agencies

By January 1950, the group workers in the official and voluntary recreation agencies were brought into the team. During the remaining 6 months of the project, these group workers, together with personnel in the project, explored ways and means of exchanging health information on the children for whom these agencies were providing services.

Summary

A demonstration Community-School Health Education Project, sponsored by the State Departments of Education and Public Health, was carried out by the San Francisco Unified School District, Department of Public Health, and State College with supplementary funds provided by the W. K. Kellogg Foundation.

A central coordinating committee with representation from School and Health Departments, State College, and County Medical Society provided the administrative framework for bringing problems into focus for discussion, joint planning, and action. As the members were able to establish empathic relationships with each other and greater understanding developed, unity of purpose, and agreement on objectives and basic philosophy were achieved.

The review and evaluation of the activities of school personnel, the relationships among staff providing services to school-age children, and the adequacy of records and other tools used in the program, was an effective means of bringing problems to light and directing joint efforts toward their solution.

Among other things, the united team approach succeeded in: (1) clarifying joint and individual responsibilities; (2) developing new records and tools for sharing and channeling information about children's health between school staffs and between the private physicians and schools; (3) making more effective and economical use of professional time and skills; (4) directing medical services to children in need and eliminating duplication by integrating private physicians' services in the total program; (5) securing the interest, cooperation and active participation of parents, physicians, and community agencies serving children; and (6) carrying out an intensive inservice education program geared to the needs of staffs serving school children.

The project demonstrated that school people and health department people can work together for a really good, effective school health program, if they have a strong desire to do so and take time to understand each other. This combined effort is not only sound, but it is economical; no more people have to be hired, no more money is required, there is no costly duplication of effort, and all the resources are used to advantage.

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[1] Mealy, Ethel, and Corbett, Alice M.: What shall I do? The classroom teacher's role in the health education program for elementary school children. *Journal of the American Association for Health, Physical Education and Recreation* 21: 28, October 1950.

Conlon, Louis G.: The organization and administration of an improved health education program for eight senior high schools in San Francisco Unified School District. Doctorate Thesis, University of California, Berkeley, Calif.

PROGRAM DEVELOPMENTS

In big and little ways, the people of the Nation keep building better ways of life and greater chances for a wholesome, satisfying childhood for its youngest citizens. Here are some notes on problems and gains gathered from reports by the Children's Bureau staff.

Hints were given at the annual meeting of the American Academy of Pediatrics in Florida in October 1953, that research relating to the cause of retrolental fibroplasia (a type of blindness occurring almost inclusively in prematurely-born babies) is producing results. . . . The Academy passed a recommendation for the fluoridation of water and a resolution backing the program of vaccination sponsored by the National Foundation for Infantile Paralysis.

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In 7 years—from 1946 to 1953—the number of rural counties with the services of a full-time public child welfare worker increased 41 percent. By June 30, 1953, 48 percent of the 2,489 rural counties of the country had such services. This compares with 68 percent of the 698 urban counties, but the increase in these counties from 1946 amounted to only 17 percent.

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Five hundred workers in 47 State public child welfare agencies concluded a period of educational leave during the year ending August 31, 1952. This represented 10 in every 100 persons employed full time in the public child welfare services program. Six out of 10 took their first year of professional training; the other 4 completed their second year. Although these workers had studied at 49 different schools of social work, more than half were concentrated in 8 of these schools.

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Recent studies of handicapping conditions in childhood provide a basis for at least *tentative* estimates of their prevalence in the United States. These indicate some 675,000 children under 21 years of age have rheumatic fever or suffer from its after effects. Cerebral palsy affects about 285,000 children, and epilepsy a nearly equal number in this age group. Nearly 5,000 infants a year are born with cleft palate or lip. In 1952 there were about 64,000 children under 18 with this malformation. Children in need of eye care numbered that year some 7½ million. Hearing loss sufficiently great to warrant further study affected about 5 percent of school children. Some 2 million children, or 5 percent of those 5 to 20 years of age, have speech disorders of such severity as to interfere with educational progress and social and emotional development.

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The four leading crippling conditions diagnosed in State crippled children's programs in 1950, according to a recent analysis made by the Children's Bureau were: congenital malformations, diseases of the bones and organs of movement, poliomyelitis, and cerebral palsy.

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Federal child welfare services funds in 1952 accounted for $1 in every $5 spent for professional services and administration (excluding payments for foster care) in public child welfare programs. The Federal share was larger in rural and low-income States than in urban, high-income States. Expenditures per child under 21, contrariwise, were larger in the high-income, than in the low-income, States. Of total public child welfare expenditures, nearly 73 percent was for foster-care payments. State and local funds were used for most of this cost.

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Teen-age efforts to do something constructive about the problems which careless or "show-off" teen-age driving create are taking several directions. A permanent Teen-Age Traffic Safety Association has been set up in **Colorado** through which teen-age clubs in the State's schools will be formed with the dual purpose of increasing awareness of traffic problems and of working to solve them as they develop locally. **Florida** has a Youth Safety Council which hopes to establish a counterpart in every high school in the State. Statewide driving clubs have been organized in several States.

An agreement to assume responsibility for maintaining a flow of information to the National Advisory Council for State and Local Action on Children and Youth was signed in October 1953 by the Interdepartmental Committee on Children and Youth, whose membership includes representatives from 9 major Federal agencies embracing 29 bureaus and offices.

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The Chief of the Children's Bureau, United States member of UNICEF's Executive Board, was reappointed in October 1953 to the Joint Health Policy Committee of UNICEF and the WHO.

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A county health department "costs about as much a year per person as a dozen eggs." A county health department "will cooperate with but not replace private physicians and voluntary health agencies." Statements such as these helped to convince the residents of **Bucks County, Pa.**, that they should vote "Yes" last November when a public referendum on the issue was held. Their 2 to 1 support of a county health department made Bucks the first county in the State to approve such a program by referendum.

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From 6 States reports have recently come of progress in public-voluntary agency teamwork in meeting the needs of childen:

North Dakota is using a committee made up of representatives of the State Division of Child Welfare and voluntary agencies to develop standards for child-caring institutions.

Pennsylvania has a similar committee to evolve standards of operation for its new adoption law.

The Catholic Charities in El Paso, **Texas**, has asked for help from the State Division of Child Welfare and the Children's Bureau Consultant on Group Care on reorganization plans for Catholic institutions.

The **District of Columbia** has a citizens' committee gathering information about child dependency and using, in the process, staff from both public and voluntary agencies as resource persons.

Administrators of protective services in Fresno, **California**, are working with other agencies and citizens' groups in an interesting way. An inter-agency screening committee has been established to which all situations of neglect

are referred. After reviewing each case, the committee recommends what referral should be made: to Protective Services, to an agency already known to the family, or to a law enforcement agency for removal of the child. Citizens' groups, such as church and service clubs, are brought in to assist in securing material things needed by the family that cannot be supplied through the child welfare activities. By this device, citizens in general are helped to understand the ways in which services work with families and children.

Colorado's Division of Child Welfare has given its State Child Welfare Advisory Committee responsibility for developing closer working relationships between public and voluntary agencies throughout the State. Under this plan, a member of the Committee took leadership in planning and chaired an institute in Pueblo on services to children in their own homes, which was addressed by the State's consultant on these services and to which workers in public and private agencies in the community came. Advisory Committee members are taking leadership in other gatherings similarly designed to promote better services to children.

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To reach unmarried mothers who might not otherwise know of the help available to them, the Texas Department of Public Welfare, in cooperation with public and private licensed child placement agencies and licensed maternity homes in the State, has just issued a pamphlet, "Helping the Unmarried Mother and Her Child." Listing the agencies and the kinds of services given unmarried mothers, the pamphlet is being widely distributed throughout the State.

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A program of nursery schools for hard-of-hearing preschool children has been set up by the Massachusetts Department of Public Health. Seven such schools, located in public libraries, public schools, and Visiting Nurse Association headquarters, have been established to help in preparing these children for regular school classes. Centers have electronic auditory training aids. Some of the children get instruction in operating and using some auditory trainer aids that can be taken home. Lip reading and speech training teachers in the public school systems staff the nursery centers, and parents help in carrying out some of the educational therapy.

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Developments in programs for children in the Virgin Islands since the Mid-century White House Conference on Children and Youth are outlined in a report, "What Bends the Twig," prepared by the Insular Advisory Commission on Children and Youth.

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Impressed by the interrelationship of maternal care and mental health effectively set forth in Dr. John Bowlby's monograph on the subject for the World Health Organization, the Greater New York Fund is making special grants, totaling $400,000 over a 3-year period, to 8 pilot projects designed to prevent family breakdown and the uprooting of children. While none of the projects is claimed to be new in concept, the Fund believes "in their present application, they are new to this community."

Recipients of the grants are expected to develop:

"(1) continuous and long-term homemaker and casework service to keep children in their own homes when the family in broken by illness or death but the physical structure of the home remains intact and a responsible parent or relative is willing and able to carry on with this help and support;

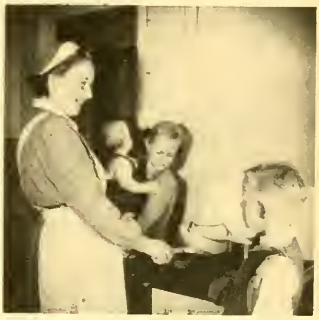
"(2) cooperative action between 2 agencies where a family is requesting placement of children but there is reason to believe that placement is neither necessary nor desirable and the home can be reestablished with the aid of intensive casework services; and

"(3) psychiatric treatment for disturbed children in their homes to avoid costly and often unsatisfactory placement or hospitalization."

At least 3 reports annually will be made to the Fund by the grantees which undertake also to make every effort, if warranted, to continue the projects after the special grants cease.

Agencies receiving the grants are: Brooklyn Bureau of Social Service and Children's Aid Society; Catholic Charities, Archdiocese of New York; Catholic Charities, Diocese of Brooklyn; Community Service Society; Federation of Jewish Philanthropies of New York; and the Council Child Development Center.

Home Help and the Nations, just received from England, reveals the widespread and growing importance of a service that is kin to the burgeoning Homemaker Service in this country, which, in some communities, is doing an invaluable job of helping to hold families together when mothers are ill or hospitalized. A report of the "First International Conference on the Home Help Service," held in London in May 1952, gives developments in Belgium, Holland, Great Britain, Sweden, Norway, Finland, Germany, Switzerland, France, Austria, and the United States, where public or private agencies under-



SWEDEN'S "home helps," characteristically are civil servants, employed by municipalities to take over the duties of a sick or overworked housewife. More than a houseworker, a "home help" looks after the children, their schoolwork, and their play. To qualify for this work, she is given 15 months of training.

take to provide trained and supervised "home helps" or their equivalent to families with special or serious chronic conditions. "The impression gained during 3 days' intensive study," says the report, "was that the home help service is one which is sympathetically regarded throughout the world." So profitable was the exchange of information between representatives of these agencies that arrangements are being developed for a second International Conference to be held in Paris in the near future, and for the formation of an International Council.

Copies of the pamphlet may be obtained for 12 shillings 6 pence, from the sponsors of the 1952 gathering, the National Association of the Home Help Organizers, 53 Jedburgh Street, Battersea, London, S. W. 11, England.

FILMS ON CHILD LIFE

Films listed here have been reviewed by staff members of the Children's Bureau. The listing does not constitute endorsement of a film, but indicates that its contents have merit. Charges for rental or purchase, not given because they change, may be obtained from distributors.

ALL MY BABIES. 60 minutes, sound, black and white, purchase or rent.

A real midwife in a meager rural setting is the heroine of this story of prenatal care and birth, filmed for use in the training of midwives in Georgia. The tenderness and insight with which the midwife helps the family constitute a humbling and touching lesson in the essentials of good "human relations," whether learned in a college course or gained through compassionate human experience. The film is "designed to improve existing services to mothers and children but not necessarily to approve or promote the particular type of care represented."

Audience: Professional personnel only. Restricted to official health agencies, accredited hospitals, medical societies affiliated with the American Medical Association, accredited nursing associations, and government agencies with programs of health education in foreign countries.

Produced by: Medical Audio-Visual Institute of the Association of American Medical Colleges under the auspices of Georgia Department of Public Health.

Distributed by: Columbia University Press, Center for Mass Communication, 1125 Amsterdam Avenue, New York 25, N. Y.

FAREWELL TO CHILDHOOD. 23 minutes, sound, black and white. (Emotions of Everyday Living Series), purchase or rent.

Both sympathy and humor characterize this portrayal of the distress of the parents of a 16-year-old who, in trying to grow up, seems to be bypassing them. Though these parents get some relief through the good offices of the counselor whom their daughter admires and confides in, there is pointed recognition in the film of the fact that there will be a succession of other familiar problems typical of adolescence.

Audience: Parents, teachers, adolescents. Should be shown only with a competent discussion leader in charge.

Produced by: Herbert Kerkow Productions for North Carolina Board of Health, under sponsorship of Mental Health Film Board.

Distributed by: International Film Bureau, Suite 308, 57 East Jackson Boulevard, Chicago 4, Ill., for sale; the following regional film libraries for rent—American Film Registry, 24 East 8th Street, Chicago, Ill.; Bailey Films, Inc., 6509 De Longpre Avenue, Hollywood 28, Calif.; Contemporary Films, Inc., 13 East 37th Street, New York, N. Y.; Visual Education Service, 116 Newbury Street, Boston 16, Mass.; Instructional Materials Center, Colorado State College of Education, Greeley, Colo.

FEARS OF CHILDREN. 30 minutes, sound, black and white (Emotions of Everyday Living Series), purchase or rent.

The frankness and sympathy of a neighbor who has been through similar problems help the parents of a 5-year-old boy to gain understanding and insight. The mother, by babying the little boy, and his father, by leaning in the opposite direction, have encouraged and reinforced their child's fears. The good features of their relations with their son are also shown, so that a realistic picture of family life, not a depressingly blameful one, results.

Audience: Parents, teachers, nurses, social workers, and all others who are interested in how children react to the personalities and practices of their parents.

Produced by: Julien Bryan International Film Foundation for Oklahoma Department of Mental Health, under sponsorship of Mental Health Film Board.

Distributed by: (Same as Farewell to Childhood)

THE HANDICAPPED GO CAMPING. 10 minutes, sound, color, loan.

That camp life is possible for children with varying degrees of physical handicap is clearly demonstrated by this picture of life in a camp for both normal and handicapped children. Enough detail is shown so that the special problems of such a camp, such as the need of an unusually high proportion of counselors, are indicated.

Audience: Camp directors and adults concerned with the needs of handicapped children.

Produced by: Agricultural Extension Service, Washington State College.

Distributed by: Audio-Visual Center, Washington State College, Pullman, Wash.

MEET MAI-DA. 20 minutes, sound, color, loan.

What can be done toward bringing about independence and a normal life in a child born without arms is illustrated by the case of a little Hawaiian girl, Mai-da and her mother spent a year in the United States learning to use prosthetic appliances. The mother's narration of how she handled Mai-da's problems from babyhood on, and Mai-da's obviously cheerful and sunny outlook on life, should give reassurance and new courage to the parents of other handicapped children, no matter what the nature of the handicap.

Audience: Nursing and medical students; also any groups interested in helping handicapped children.

Produced by: Kessler Institute for Rehabilitation, Occupational Therapy Department, Pleasant Valley Way, West Orange, N. J.

Distributed by: Same.

SCHOOL HEALTH IN ACTION. 27 minutes, sound, color, loan.

How a town is aroused to action and the eventual formation of a health council is the theme of this film, itself a cooperative venture of the Oklahoma State Health Department and the State Medical Society. The community is alerted because of the spark set alight in a PTA group by a teacher keenly aware of the need of safety education.

Audience: Community organizations interested in bettering health conditions in schools.

Produced by: Sam Orleans and Associates, Inc., for the Oklahoma State Department of Health.

Distributed by: Oklahoma State Department of Health, Division of Health Education, 3400 North Eastern Avenue, Oklahoma City 5, Okla.

ORE U. S. GOVERNMENT PUBLICATIONS FOR PROFESSIONAL WORKERS

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DUCATION DIRECTORY, 1953–54. S. Department of Health, Educa-n, and Welfare, Office of Educa-n. 1954. Part 1, Federal Govern-nt and States. 55 pp. 25 cents. rt 2. Counties and Cities. 92 pp. cents. Part 3, Higher Education. pp. 55 cents.

The Education Directory of the Office Education, issued annually, consists 4 parts, the first 2 of which have ently come from the press.

Part 1 lists the professional personnel the Office of Education, the princi-l State school officers, the executive icers of State library extension agen-s, and the principal education officers the Bureau of Indian Affairs, Depart-nt of the Interior.

CCIDENT FREQUENCY AND ACE OF OCCURRENCE AND RE-TION TO CHRONIC DISEASE; mple of white families canvassed at nthly intervals, Eastern Health Dis-ct of Baltimore, 1938–43. Selwyn D. llins, Ph. D.; F. Ruth Phillips; and rothy S. Oliver. U. S. Department of alth, Education, and Welfare. Pub-Health Monograph 14. 1953. 68 pp. cents.

With accidents causing nearly a third of the deaths of children 1 to 14, this study of accidents to persons of all age groups should be of value to many workers interested in saving children's lives. The study found the highest relative frequency of all accidents occurring among children under 15, and the lowest among persons 15 to 34.

Part 2 lists, by States, superintendents of county schools, of supervisory-district or union schools, and of urban schools, by States. It also lists superintendents of Catholic and Lutheran parochial schools.

Part 3, Higher Education, lists institutions offering at least a 2-year program of college-level studies and meeting stated criteria. Among the types of information presented are: names of president and of other officers; accreditation; legal control; enrollment; changes in names of institutions, of classification, or of location; and type of programs offered.

In press is Part 4, Education Associations.

TRAINING AND RESEARCH OPPORTUNITIES UNDER THE NATIONAL MENTAL HEALTH ACT. U. S. Department of Health, Education, and Welfare. Charlotte Green Schwartz. Public Health Service Publication No. 22. Mental Health Series No. 2. Revised January 1954. 16 pp. 10 cents.

A detailed explanation of the Public Health Service program of mental-health traineeships, grants, and fellowships.

A DIRECTORY OF 2,660 16-mm. FILM LIBRARIES. By Seerley Reid and Anita Carpenter. U. S. Department of Health, Education, and Welfare, Office of Education. 1953. 172 pp. 25 cents.

An annotated list of film libraries, compiled for the use of teachers, school administrators, community leaders, and others who use or wish to use motion pictures in their educational and informational programs.

REHABILITATION OF MENTAL HOSPITAL PATIENTS; review of the literature. U. S. Department of Health, Education, and Welfare. Public Health Monograph 17. 70 pp. 1953.

"Within the last 2 decades," says this report, "the orientation of mental hospitals has been significantly changed. The conception of the function of the hospital as a custodial institution for mental patients has been replaced by the conception of the hospital as an institution whose purpose is reeducation and reintegration of the patients into the community."

The report reviews and analyzes current published literature concerning the hospitalized mentally ill—adults and children.

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CHILDREN'S BUREAU
Martha M. Eliot, M. D., *Chief*

JULY · AUGUST 1954

children

A PROFESSIONAL JOURNAL ON SERVICES FOR CHILDREN AND ON CHILD LIFE

FOSTER-FAMILY CARE
FOR DISTURBED CHILDREN

PARENTS AND DELINQUENCY

A NURSERY SCHOOL
FOR THE CEREBRAL PALSIED

INTERCOUNTRY ADOPTIONS

VOLUME 1

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JULY–AUGUST 1954

children ®

a professional journal on services for children and on child life

(*formerly* THE CHILD)

The first annual award of the Baltimore Council of Social Agencies has gone to the Family and Children's Society for the program of foster care for emotionally disturbed children described herein by Verna Waskowitz. Miss Waskowitz, a graduate of the Pennsylvania School of Social Work, has supervised the development of specialized areas in foster-family care since the agency was created by the merger of two predecessors in 1944.

Are parents to blame for juvenile delinquency? In reporting on 2 days (and more than 400 typed pages) of conversation on the question, Helen Leland Witmer has again culled the gist from a great mass of material—as she did as co-organizer of the fact-finding material for the Midcentury White House Conference on Children and Youth. Formerly professor at the Smith College School of Social Work and at the School of Social Work at the University of California at Los Angeles, Dr. Witmer has been with the Children's Bureau since 1951.

Specialization in psychology and additional study under an orthopedic surgeon have equipped Louise G. Yum for directing the work with preschool cerebral-palsied children she describes in her article on the nursery at Michael Reese Hospital. Except for a 3-year interval doing special work for the Illinois Commission on Handicapped Children and for the Chicago Board of Education, Mrs. Yum has been with this nursery since she helped organize it in 1944. She has also lectured extensively.

When Eugenie Hochfeld writes on intercountry adoptions she can bring to her subject a background not only of professional education and experience in the United States but of firsthand knowledge of the cultures of a number of European countries. Born in Russia, she was educated in Czechoslovakia, receiving a law degree at the Charles University of Prague, but spent the major portion of her prewar life in Paris. During World War II she worked with the refugee program of the American Friends Service Committee in the south of France. She received her social work degree from the New York School of Social Work, Columbia University.

A psychologist with a child-centered focus, Dale B. Harris, who reviews the important study on war-separated children prepared by Lois Stolz and her associates, has published 20 major articles and monographs on child behavior and parent-child relationships. Onetime educational director for the Minnesota State Training School for Boys, he has been with the University of Minnesota for the past 14 years, except for 2 years of active service during World War II as captain in the United States Marines.

frontispiece

"SIBLINGS" the social scientists would call these two little boys playing in the waves—but "brothers" seems more aptly to describe the "feel" of the relationship the camera has caught. Photo by Eva Luoma, Weirton, W. Va.

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READERS' EXCHANGE

BARTLETT: First "what," then "how"

Harriett Bartlett's thoughtful and clarifying discussion of public health social work ("Perspectives in Public Health Social Work," CHILDREN, vol. 1, no. 1, pp. 21–25) was of particular interest to me because of an opportunity I have had during the past few years to meet with medical social consultants in health programs in a series of seminars and workshops in which we have examined the "what" and the "how" of their *core* professional activities. In her usual scholarly fashion, Miss Bartlett has identified a number of questions which can serve as "guide lines" and thus give direction and focus to an ongoing process pointed toward a more precise delineation of the professional role of the social worker in the field of public health.

I was particularly impressed by Miss Bartlett's emphasis upon the fact that the choice and use of different methods are dependent upon the goal established by the social worker and the requirements of the particular problem-situation with which he is dealing. I have noticed, as I have discussed various problems with medical social consultants, that the methods of social casework have increasingly been endowed with special prestige values or status and that other types of methodology pointed toward different purposes hold less significance for them.

In reality, the methods of social casework are poorly suited for the attainment of some of the broader goals with which the social worker in the field of public health must become identified.

Like other professional workers in this field, the social worker must be able to move from his concern about and focus upon a single case to a concern about the broader group of cases of which the one he has encountered is but an illustration. As his focus of attention is extended from *one* case to *many* cases which reflect a similar problem, the methodology he employs in his problem-solving efforts must be appropriately related to his expanded goal. Underlying *all* of his professional operations, regardless of specific goal or methodology employed is a basic core of professional philosophy, knowledge, and skill which are put to work in different ways, toward different purposes.

Miss Bartlett's emphasis upon the necessity to think first in terms of *purpose* and second of *methodology* seems important, because the "how" is fashioned in the light of "what" and must be in consonance with its requirements.

Eleanor E. Cockerill,
Professor of Social Casework,
University of Pittsburgh

Challenging questions

In presenting her clear interpretation of the development of social work in public-health programs ("Perspectives in Public Health Social Work," CHILDREN, vol. 1, no. 1, pp. 21–25), Harriett M. Bartlett suggests that the difference between the social worker in a hospital and the social-work consultant in a health department lies in the multiplicity of functions assumed in the health department and the breadth of concern for large numbers of persons rather than for individual patients.

One might raise the question as to whether this is a basic difference in function. It seems to me that if one compares the role of the social-work consultant in public health with the responsibilities of a social-service department of a hospital, one will find the comprehensive services of both to be the same, with the one distinction that the hospital department's interest is primarily limited to hospital patients whereas in public health the concern is for all people, not just those under care of the public-health department. Theoretically, if the hospital social-service department is adequately meeting its responsibilities it will be concerned with the hospital's program, policies, and procedures as they affect the individual being served—with the adequacy of community services to meet the needs of patients, with consultation to other members of the hospital and to community agencies, as well as with the more obvious functions of social casework, teaching, and research.

Miss Bartlett raises certain key questions in order to clarify the social worker's role. Perhaps it would be well to add that this role often changes rapidly and in unexpected ways with changing circumstances, and thus requires flexibility.

With the goal of developing teaching material and to clarify functions, Miss Bartlett urges public-health social workers to record at least one full record a year. However, I question if such cases would be a sound sample for the study and analysis of the practice of social work in public health since they would tend to be those in which the social worker out of greater interest provided more than average service, and so would not give a balanced view of practice in general. However, I agree that such a sampling could provide a realistic beginning to the development of a broader study.

Miss Bartlett also raises the question as to whether casework practice needs to be strongly imbedded in the public-health program. It seems to me that social-casework service will be necessary if the social worker is to keep her skills sharpened in order that she may continue to be helpful as a consultant.

Miss Bartlett has raised several challenging questions and has given us sound suggestions which we, as social workers in public health, should consider seriously and test through practice.

Elizabeth P. Rice,
Associate Professor of Medical Social Work, School of Public Health, Harvard University

BECHTOL: Delabeling "the amputee"

In a concise package describing some of the research programs and services available for problems of individuals born without or deprived of arms or legs through amputations, Dr. Charles O. Bechtol has indicated what other specialists besides the physician are required for adequate care of children with amputations. ("Artificial Limbs for Child Amputees," CHILDREN, vol. 1, no. 3, pp. 92–96). However, he omits the nurse and refers only briefly to the social worker.

Too much stress cannot be laid upon sound guidance for parents following the birth of a child with congenital amputations or for the individual who has an amputation following injury or the result of a disease. The attitudes and feelings of parents toward physical imperfections should be dealt with not only at the beginning of the problem but prior to planning for the prosthetic device. Such early care will prevent

much unhappiness later. Followup is most important and should be continued during the growth and development of the child.

The "I am an amputee" idea and the term "amputee clinic" should be discontinued at once. The individual is not amputated unless we—the public and the professionals in particular—separate him from the group by constant repetition of his disability. How often does one professional say to another "that upper-arm amputee" or "the double amputee," not "John J." or "Mary X," thus stressing the physical defect and not the person? Many may be well fitted with prosthetic devices but their psychological selves may be only partly helped.

As Dr. Bechtol has said, there is need for research into prevention of congenital deformities and for increased safety measures. In addition intensive help to prevent continued psychological injury is needed as well as experimentation in methods of providing such help. Delabeling of the "amputee" is imperative. The public needs more knowledge about those with amputations and the prosthetic devices which enable them to function efficiently if individuals are to lead free and effective lives.

Mrs. Alice Fitzgerald,
Associate Director, Association for the Aid of Crippled Children

HARDER: An "ounce of prevention"

That "an ounce of prevention is worth a pound of cure" is graphically illustrated in Theresa Harder's description of the functioning of the medical social worker in a child-health clinic ("Helping Mothers Handle Emotional Problems," CHILDREN, vol. 1, no. 3, pp. 97–101). Studies in recent years of family inter-relationships, and particularly parent-child relationships, have demonstrated the vital importance of emotional security as well as good physical care for the infant and preschool child. Parents in trouble cannot give the all-round care necessary even though they have good intentions and desires, and help with the parents' trouble may be a way of preventing troubles for the child.

Bringing the baby to a child-health clinic is one piece of evidence that a mother does have good intentions. Although many mothers cannot describe and are not really aware of the relationship between their troubles and health, in many instances they come to the clinic hoping for help with their total problem. The social worker in the clinic is in a strategic position to help identify and alleviate these difficulties. Only infrequently would these same mothers go directly to a social agency.

The opportunities are legion in a child-health and well-baby clinic for prevention of health problems, emotional problems, and the whole gamut of social and emotional difficulties. The description of medical social function and use is clear. I only wish the preventive aspect were more definitely pointed out.

Elizabeth McKinley, Directors,
Social Service Department, University Clinics, University of Chicago

FRENCH AND BEARD: Encouraging citizen interest

The story by Dr. French and Dr. Beard of Anne Arundel County's health program, "Citizens Take Hold" (CHILDREN, vol. 1, no. 2, pp. 57–63), is very encouraging—not only because it meets a real need but because it has been developed on such a sound basis, stimulating action but not moving too fast for citizen participation and support.

I find that health programs move very slowly in rural areas, partly because there is great reluctance to add anything to present taxes, partly because there is a great lack of information about what could be done, and partly because there is no group (governmental or voluntary) which has taken the continuing responsibility for arousing interest and support.

The story of the success of this program in Anne Arundel County should not only stimulate interest but encourage action in many other places. It would be extremely helpful in promoting citizen participation in other areas if it could be given wide publicity in a national magazine.

Mrs. Raymond Sayre,
Former president, Associated Countrywomen of the World

From the community up

Although there are many instances of how communities work together to meet their own special health needs, not nearly enough has been put on the record for the guidance of others who are aware of needs in their own communities but do not know where to make a beginning. For this reason, I welcome the article by Drs. William J. French and J. Howard Beard ("Citizens Take Hold," CHILDREN, vol. 1, no. 2, pp. 57–63), which tells in detail how in Anne Arundel County, Md., in one town after another—each different from the other—citizens began to sit down together. Their common thinking on one problem mushroomed into concern for many other needs. In one place, it was the high incidence of tuberculosis, in another lack of prenatal care, in another wartime growth of population, in still another a typhoid outbreak. First there were loose associations which later became local health associations, and still later these were related to a county health council.

Nor can I pass without mentioning one other outstanding feature of this story. Although local citizens took the initiative, both State and Federal governments helped—with money, with consultant service, and with accumulated experience. That too is the 20th-century pattern, for we have learned that, like no man, no community is an island unto itself.

Reginald M. Atwater, M. D.,
Executive Secretary, American Public Health Association

ANDREWS: It takes money

Those who are deeply concerned about the conditions under which migrant farm children live and work welcome Miss Andrews' article, "Moppets Who Migrate" (CHILDREN, vol. 1, no. 3, pp. 86–91). It raises three points of special significance.

First, it recognizes the complexity of the problem and the difficulties involved for the community, for State and local officials charged with responsibility for housing, health, education, and welfare, for employers of migrant labor, and above all for migrants themselves. The handicaps inherent in a nomadic way of life are intensified by the very uncertainties and perplexities that confront growers, public officials, and the community generally.

Second, a very clear picture is given of the services that are needed for migrant families. As the National Child Labor Committee learned long ago, problems of education, child labor, housing, health, and welfare are all closely related. No one can be dealt with effectively in isolation. Miss Andrews

(*Continued on page 160*)

What can be done for children who are very sick emotionally? Baltimore has found one answer in . . .

FOSTER-FAMILY CARE FOR DISTURBED CHILDREN

VERNA WASKOWITZ, M. S. W.

Supervisor of Children's Division, Family and Children's Society, Baltimore

THREE YEARS OF EXPERIENCE in Baltimore in offering a foster-home-care program for children who are severely handicapped emotionally has shown that many can be helped in a family setting with intensive casework and psychiatric services.

For several years an awareness had been growing in Baltimore of the need for many adequate services and facilities to care for emotionally disturbed children. The Family and Children's Society, a private agency, had occasionally accepted and planned for a disturbed child who did not fit into regular foster-family care. Therefore in 1949 when a committee of the local Council of Social Agencies recommended "specialized foster-family care" as an appropriate function of a private agency, the fact that the agency already had helped many such children gave it the courage to begin to plan a special foster-care program for them.

We began on June 1, 1951. By March 1, 1954, we had accepted 51 children in this program. These were all children who, because of acute behavior problems, could not remain in their own homes or in regular foster-family or group care. Some of them probably would have gone into specialized institutional care had this been available, but it was not. They had been referred to us by the Department of Public Welfare, which purchases care from us on a part-pay basis, the juvenile court, psychiatric clinics, and social agencies. These children manifested their emotional disturbance in stealing, running away, poor adjustment in school, and occasional deviant sexual behavior. Most of them came from broken homes and parents who had alternately cared for them and left them in the hands of friends or relatives.

We purposely have adopted broad criteria for selection in order to determine the types of children who could be served in special foster-family care.

In general we choose those children who we believe are amenable to casework and psychotherapy. Occasionally, however, we accept a very young child with a doubtful prognosis in the hope that we can find the answer to his problems. With some exceptions, we use the following guidelines:

1. We accept children up to 16 with potential I. Q.'s of 70 or over, regardless of the type of their behavior difficulty, when this behavior comes from living with emotionally disturbed, rejecting parents or parent surrogates.
2. We reject children with major symptoms of severe fire-setting, and established homosexuality; those who have been diagnosed as psychotic or as suffering from organic brain damage; and older adolescents so damaged in capacity for interpersonal relationships that foster-family care cannot help them.

Program Differences

When we began the program we knew it would involve many differences from a normal placement program, but what and how great these were, we did not know. Therefore, we decided to centralize the program in one supervisor and one worker in

order to establish a body of knowledge and experience. We soon found that because our usual ways of working were not effective or helpful, we had to create new ways of doing the job. Slowly some basic principles and structures evolved which affected the entire program. These especially involved the use of the psychiatrist, casework with the child and foster parents, and the development and use of the foster family.

Although we began our experiment without a psychiatrist it soon became apparent that the caseworkers needed the diagnostic service and continuing support of a psychiatrist in order to understand the meaning of the children's complex patterns of behavior and to develop new ways of helping them. Therefore a psychiatrist was engaged to participate in the development of the program.

Currently the psychiatrist meets with the division supervisor, the program supervisor, and caseworkers regularly 2 hours per week on a consultation basis. She also sees children for diagnostic purposes as the need arises.

Intake Procedures

Intake summaries are considered first by the division supervisor and the program supervisor. Some cases are immediately eliminated. Others are reviewed with the psychiatrist for further consideration. Often more complete medical and social histories as well as direct contact with the family and the child are needed in order to evaluate the child's capacity to use the care we can provide. At this point the case is assigned to a worker for intake exploration who brings it back to the "consultant group" for discussion. Occasionally when there is a question about a child, the psychiatrist sees him and joins the consultant group in a consideration of whether intensive casework service in foster-family care and the psychiatric-clinic resources available to us, are likely to help him. We have to weigh the limited availability of treatment resources and the possibility of being able to sustain a child in placement pending his acceptance for treatment.

At the point the consultant group feels we know the child and can accept him we are ready to select an appropriate foster home for him. The psychiatrist with her knowledge of the depth and degree of disturbance in the child helps the agency avoid some of the pitfalls of placement. The selection of a particular foster-home setting involves weighing many factors against the background of the child's earlier experiences and relationships. The locale of the foster home and its availability to special educational facilities must be considered, as must the size of the foster family, the relationships of the members to each other, the presence or absence of other children.

Of equal importance to the selection of the foster home is the preparation of the child and parent for placement, the timing of placement, and the preparation of the foster family. For a very anxious child we may use shortcut preparation. Occasionally we have asked foster parents to write the child confirming their wish to have him in their home. We have learned that sound placement is a highly individualized process based on sensitive understanding of the people involved, and an ability to be creative in meeting situations as they arise.

The supervisor and caseworker discuss individual cases at intervals following placement when they believe this would be profitable. The discussion might focus on a particular point or an entire case. For instance one discussion revolved around a caseworker's feeling that it would help little Johnny to see his mother, although the original plan was to keep the family out of the picture until he had become somewhat settled.

Family Background

In general the parents who are still in the picture are so emotionally disturbed themselves that our emphasis has been to help them sustain placement rather than to change in relation to their children. We have found that they can mean much to their children if we are sufficiently sensitive to be able to help them do what they are able to do. We try to support every bit of parenthood, such as having the mother help in the selection of clothing and go with worker and child on a shopping trip; or by arranging for the mother to visit the child in the agency office. However, our focus necessarily has been on our work with the child and with the foster parents.

These children have never had a relationship with anyone with strength and love enough to accept both their love and their anger. No one cared consistently enough for them to give them the feeling that they mattered. It takes a skillful and strong worker to be able to accept all the hostility accumulated in such a child, to bear with his erratic behavior, and to stand by him until she is able to penetrate his defenses.

The child whose relationships have been damaged by unhappy experiences expects similar experiences

with the caseworker and with his foster parents. At first he can only relate to the agency and its setting; after a while he usually can move to a more personal relationship with the caseworker. However, it takes him much longer to find his identity with the foster family. Therefore the agency, through the caseworker, must provide the strength that sustains the child in placement.

Casework Treatment

The casework-treatment relationship with the child begins before placement. He usually comes to the office several times until he is familiar with the playroom and the caseworker's room, has met the supervisor, and has gradually discovered that the agency and its people are there for him. The physical aspects of the agency have great significance to him. After a while he bounds right up to the playroom to see if his things are there, or if his favorite candy is in the candy box. Later he wants to see if the supervisor is there.

We have discovered that the child finds security in the sameness and repetition of the activity carried on with the worker whether in clinic visits, car rides, or visits to the same drug store. His reliance on familiarity shows up in his concern over changes. If the worker uses a different agency car than usual he wants to know where the other one is, whether anything happened to it. These tangibles have meaning for him and help him begin to trust the worker.

For many months no foster home can be enough for such needful children. Foster families are normal families and the routines of daily living will not allow for all the persistent testing which is characteristic of a seriously disturbed child. Because such a child attempts to recreate continually the damaging situations that caused the maladjustment, the foster family may feel caught and discouraged. Jimmy's foster parents felt this way when he first came to live with them for he would alternately keep to himself for hours and run through the house, slamming doors; refuse to eat and stuff himself; ignore other children or hurt them with his aggressive play, flying into a rage if interfered with. All of this behavior came from an effort to incur their rejection and thus prove to himself he was unloved and unwanted.

The caseworker serves as the consistent adult in the child's life, really caring what happens to him until he can feel this and is ready to take on a relationship with his foster family. She is the bridge between the child's past experiences and his present foster home; thus, she is important for the child in a way different from foster parents. She arranges for him to see his own parents as he needs to test out where he is in relationship with them.

The caseworker sees the child regularly, usually on a weekly basis for about a period of 3 months. If a child goes into psychiatric treatment, the caseworker prepares him for this, takes him to and from the clinic, and explains the plan to the foster parents and helps them handle problems which arise. She also works with the clinic staff, as much goes on between the child and worker which is useful material to the clinic and about which the worker may need the clinic's interpretation. Weekly contacts with the child and with foster parents taper off as the child settles into the foster home.

In the process of casework treatment we have found that as the caseworker takes responsibility for many of the aspects of the child's care—medical, school, clothing, trips—she has a natural, more spontaneous medium in which to work with the child.

For instance, when David went with the caseworker for his regular treatment for ringworm, he tried to prove to himself that she too would reject him, by grabbing the car wheel, putting his foot on the gas, getting another child's hands caught in some pliers. The caseworker accepted his anger but refused to allow him to hurt himself or anyone else.

On another trip he brought out his guilt about the incident and when the worker showed she did not reject him he relaxed noticeably. Although she was sympathetic toward his dislike of the ringworm treatment, she held him to the necessity for treatment, thus both supporting and limiting him as circumstances indicated.

As the child settles in the foster home, many of the child-care responsibilities carried by the worker begin to shift to foster parents. This happens naturally as the child includes and turns to the foster parents. However, the caseworker is always available at crisis points.

The Foster Families

In the early days of this program, we hoped to develop a kind of temporary care that would help the child move to long-time care. We thought that we could provide a more controlled setting with foster parents especially prepared to do an intensive job for a limited period of time. However, we soon found that many of these children already had experienced too much moving about. More moving, we felt, would only intensify their inability to establish and sustain meaningful relationships. Therefore, in our present program, the child remains with the foster parents, who are beginning to have real meaning for him, as he is to them.

We began our program by selecting foster homes already in use. There we could find foster parents with understanding and acceptance of difficult behavior and with security, strength, and patience in dealing with children. They already had a working relationship with the agency based on mutual respect and trust.

However, new families willing to take disturbed children were too few! Most applicants wanted children who could readily fit into their homes. Therefore we had to make a special recruitment effort.

We have been using the same media for recruiting special foster homes as we have for regular homes—established foster parents, the newspaper, the various churches, and special radio appeals. We have tried various approaches. At first we asked prospective foster parents to take on "problem," "emotionally disturbed" or "upset" children, but regardless of how we said it, it was obvious that people were afraid or had little understanding of what we meant. Later appeals based on specific children, emphasizing their special needs for warm, patient, understanding foster parents got more response.

Only a small portion of applications, however, have come to complétion of study. Currently we are approaching some ministers individually in the hope that they might interest some people. We believe it will require a broad, long-range interpretation job to convince people that it is possible to help these children and to induce them to undertake the task.

There are some basic differences in focus involved in the process of home study for these children. We must look for special qualities over and above those usually expected in foster parents. These include: understanding and acceptance of difficult behavior as symptoms of conflict; more than usual ease with and sensitivity to children as evidenced by their experience with children; imagination, and a spirit of adventure and challenge.

We have learned to expect some common reactions to the mention of "problems" and "disturbed children." Some families will be scared and reluctant, others will minimize the difficulties. Through a gradually developed skill we have helped some families to get beyond their fears to a realization that they had the strength and capacity to undertake the job. This has involved getting them to see that while they could not through these children expect to satisfy a need for love, they could participate with the agency in a creative process in helping the children to discover that they can love and be loved.

Mr. and Mrs. Barnes,[1] both middle aged, answered one of our advertisements. Having raised three boys, now with families of their own, they were feeling lonesome. Used to having "live wires" about the house, they had too much time on their hands and were "lost without children to care for."

Since these people showed a great deal of sensitivity to children, we tentatively suggested our need for homes for disturbed children. Their immediate reaction was to shy away. After all they had raised a family. When we suggested that was just why we thought maybe they could do the job, their interest was aroused. But neither understood what we meant by "disturbed children." Finally it dawned on them that we were talking about children who behaved like a neighbor's neglected children whom they had kept for almost a year. They described how shy and scared one of them was and the peculiar things she used to do in contrast to another who fought back aggressively. "The children didn't know what kindness or loving was." After a time

[1] All names in this article are fictitious.

the children improved a little but "it takes longer than that to make up for the years they went without." Then, a little later, "I wonder if they ever learned to love anyone."

We knew then these people were beginning to understand what we meant and had the capacity to accept the unknowns. Later on when the discussion turned to ways of handling problems they showed much interest in the worker's ideas, relating them to their own experiences. Eventually, Mrs. Barnes expressed their appreciation of the agency's role by saying, "Well, if I only had somebody to talk things over with in those days, it would have been easier." They were still not sure, however, that they wanted "to stick our necks out again," but finally decided they did.

Greater Expectations

The prospective foster parents are told at the outset that more will be expected of them than of the usual foster parents, that there will be more contacts with them and a deeper involvement of themselves. Thus the caseworker and foster parents begin to discover together how much foster parents are willing to allow the agency to be in the situation with them and to what extent they are willing and able to meet upsetting experiences. Can they trust the agency to carry as much control over the child as we know we need to carry? Can they accept the fact that emotional factors have caused this disturbance in children, that there are no ready solutions for these, but that with the caseworker they may find a way to be helpful? How do they feel about psychiatry since it may play an important role in this process?

We recognize our greater expectations of these families by paying a higher board rate to them than to others. Regular board is $10 to $12 a week per child, depending on age. For special foster care we have been paying up to $15 a week, the exact rate being determined individually. We also take responsibility for many more extras.

Although we have placed some children in homes in which there are other foster children and in some where the foster parents have children of their own, we have been careful that this is diagnostically sound. Any competitiveness or movement of children in or out of care creates additional problems for the child who cannot take it. Usually we do not place more than one child in a family and in most cases our child must be the only child in the foster home.

As soon as a foster home has been selected for a particular child, the caseworker visits the family. The foster parents have already been told who the supervisor of the program is and that she will be available at the office whenever the worker is not. They have also been told who the caseworker will be and that she will make arrangements to see them. The worker begins to establish her relationship to them as quickly as possible as the person with whom they will be working closely and intensively.

Just as the child needs the strength and support of more of the agency than just the caseworker, so, too, do the foster parents. Nothing can be more threatening to new foster parents than to have a child run away, which is common among these children. To be able to share this immediately and have the agency take charge can bring enough relief to enable them to go on with us and to accept the child where he is. They lose their fear of future unknowns as they work with us and gain the assurance that the agency always is on hand. Soon comes the time when foster parents can say to the caseworker, "You need not be concerned about this, Miss S., Jimmy's run away again, but *we'll* find him."

Only in establishing a secure relationship with the foster parents can the caseworker help them understand the behavior of the child and their own reaction to it. As the caseworker accepts the child's regressive or delinquent behavior, showing that this is to be expected, she relieves their sense of failure and guilt. The responsibility and authority that the agency and caseworker carry for and with these children, and their conviction that the children can be helped, are the most important factors enabling the foster parents to carry on.

When Mrs. Howard, a foster mother of considerable experience and strength, said one day, "Thank you for having such faith in the child—Thank God he has come through" she meant "thanks for standing by me and having faith in *me*." We had given her a very sick child who improved amazingly, then regressed. Psychiatric consultation, together with our own conviction, made us believe this was temporary. We knew Mrs. Howard loved this child and we had seen him improve slowly with her. We saw her regularly and helped her understand and withstand his behavior. But we were ready to help her give him up to a treatment center if necessary.

Caseworkers and Caseloads

We have been selective about the caseworkers we have used in this program and also about the assignment of cases. All of our caseworkers are pro-

fessionally trained, and most of those in the program have had some psychiatric-clinic experience and have shown special sensitivity and capacity in work with disturbed children. Other caseworkers who have demonstrated skill in working with certain types of children, such as adolescent boys or adolescent girls, have been assigned such cases.

Determination of how many cases a worker can carry has been based on consideration of the amount of attention and service required both by the child and by foster parents. The frequency of the contacts with the child and foster parents in the beginning and when psychiatric treatment is involved, and the fact that some of our best special homes are in rural areas, mean that the caseworker can handle only a few of these children at one time.

These cases also require more contacts with the school than others in regard to placements and other problems presented by the child's behavior. The caseworker also keeps the courts, the police, and community leaders aware of the program and its purposes.

More demanding on the worker than the tangible factors is the emotional content of these cases. In spite of her experience and growing skill, the worker is bound to be disturbed when Johnnie gets out on the fire escape and pretends that he is going to jump, or when Billy dashes in front of moving traffic. Another demanding factor is the disorganization involved. When Johnnie has been located after running away the worker has to get him; when the school is exercised about something, the worker is called. Such emergencies make it almost impossible to follow a well-organized schedule.

For these reasons we believe that a workable caseload is from 12 to 15 children under care, with two or three children in psychiatric treatment at a time. As children achieve some stability, additional children can be added.

Results

Of the 51 children who have been placed through our special program, 44 are still in care. Thirty-five of these are in foster-family homes. The remaining 9 are still receiving service, but are not in foster homes; some are with parents or relatives and are adjusting, beginning work and moving toward self-support and independence; some are in institutions where they need us as the one sustaining and meaningful relationship in their lives, especially since this institutional care will be temporary.

Seven children have been discharged from care. All but one of these were unable to use foster-family care positively, so that institutional plans were made for them. The other child used care well, and his family situation changed sufficiently to enable him to return home.

Evaluation

We periodically evaluate the progress of the children under care, rating their adjustment to foster family, to school, and to their peers. In these evaluations we have taken into consideration not only the caseworker's observations, but the opinions of foster parents, the reactions of teachers and principals, as well as of other people in the child's life. Our evaluation is not an attempt to show emotional change, but to indicate to what extent the children are able to live satisfactorily in foster-family care. However, improvement reflects emotional change.

Of the 35 children now in foster-family care, 27 have been under care from 6 months to 3 years and 5 months. Eight have been with us less than 6 months, and therefore an evaluation of their adjustment at this point would be premature. Of the remaining 27, 17 have made good adjustments to foster family, school, and peers; 2 have made fair adjustments; and 8 mixed adjustments, that is, good in one or two areas, fair or poor in others.

Of the 9 children still receiving service but not in our foster care, 6 are making good or fair adjustments to parents or relatives or institutions; the remaining 3 cannot yet be helped with the resources available.

We have found a way to treat some children severely damaged in parental relationships through placement in foster-family care and we have enabled them to live satisfactorily in the community. This is an evolving, developing process and we are learning and changing with experience. It is too early to know fully what children can be most helped by our program. We have accepted children within a wide age range, the young child as well as the adolescent. Some children are more disturbed than others. Several children needing clinical psychiatric treatment have had to wait over a year before treatment could begin, and this delay was and continues to be a problem. The results thus far have been encouraging, although we can wonder how firm and steady their adjustment will continue to be. Perhaps the next few years will give us more evidence.

PARENTS AND DELINQUENCY

HELEN L. WITMER, Ph. D.

Director, Division of Research, Children's Bureau

ALL OVER THE COUNTRY TODAY, there is a growing demand that parents be held firmly to account for juvenile delinquency. In many States it is being proposed that parents be made automatically responsible for the property damage their children cause. In some States the expedient of jail sentences for parents is being considered.

Delinquency is on the increase, juvenile-court statistics imply. But is an attack on parents wise? Will it help—or will it make things worse by adding to parental jitters? And is it fair? Are parents to blame? If so, what parents, to what extent, and in what ways? And if some children's delinquency is traceable to parental factors, by what means can parents be helped to carry out their responsibilities better?

These questions recently were the subject of a 2-day discussion between members of the Children's Bureau staff and a group of 15 psychiatrists, psychologists, sociologists, and social workers who, from their daily work, know delinquents and their parents well. The gist of what these people said is reported here.

Parents Part in Delinquency

The meeting opened with a discussion of whether the group in speaking of parents' being responsible for their children's delinquency would mean legally responsible, morally responsible, or responsible in the sense of cause and effect. Actually all three meanings were used in the discussion that followed.

Parents may contribute to the delinquency of their children by their absence from home, one person said. A survey of some 1,800 juvenile delinquents showed that approximately 60 percent were products of broken homes. However, many of these children had brothers and sisters who were not juvenile delinquents. Therefore, the broken home cannot be the whole story.

"Children do find their roots in their parents," said another, "but the degree to which they find them hinges upon the stability and harmony and warmth of the home. A broken home with one parent missing can be more stable than a home with two parents who are continually at odds."

"Some parents actually encourage their children to steal," said Edwin Powers, director of research, United Prison Association of Massachusetts. He told of a boy who was praised by his father for bringing things home from the 5- and 10-cent store.

"You could probably multiply the illustration of deliberate stimulation to steal by a few thousand, and get the number of parents who unconsciously stimulate their children to strike back at society," said another discussant. "These parents have been hurt. As a result they are opposed to a wide range of social institutions, including schools, police, and social workers and let their children know it."

"Then there's the matter of parents setting bad examples. Johnny's father comes home after putting through a highly questionable business deal and says 'Pulled a fast one today.' What is the kid going to think?"

Adverse parental attitudes, adverse parent-child relationships also came in for considerable discussion as factors in delinquency causation.

"Parents are sometimes unable to give the youngsters a sense of belonging," said a psychiatrist. "The youngsters feel that people important to them don't care. As a result, they develop a considerable degree of antagonism."

A school social worker spoke of the feeling of insecurity among both predelinquent and delinquent children, which often springs from too high expectations rather than from neglect.

A psychiatrist told of a "small number" of parents who frankly dislike their children. In that kind of a situation "there isn't much you can do to help."

Are Parents to Blame?

In spite of such illustrations the idea that parents are usually the primary cause for delinquent behavior was sharply challenged by Richard H. P. Mendes, director of the South Brooklyn Neighborhood Houses in New York. He told of what happened to a group of Puerto Rican boys who came to his settlement—"a pretty conforming group" at first. However, a gang in their school district began stopping them individually on the street and in school corridors, "shaking them down at point of a knife or under threat of dire consequences."

The Puerto Rican boys were all living under real terror and naturally wanted to fight back. The settlement-house workers dissuaded them, but things went from bad to worse. Because the boys weren't fighting they were subject to more and more abuse. After about a year and a half such tension had built up inside them that they started taking it out on the settlement house in vandalism.

"When we in the settlement house became cops instead of friends, there was very little we could do to help the boys," Mr. Mendes said.

"Finally, they had their fight. And they are still having their fights—those of them who are around, for many of them are now in prison."

Mr. Mendes said that the parents of these Puerto Rican boys were desperately upset at what was happening, and they tried their best to do something about it. "How could they be blamed?" he asked.

But what of the parents of the children in the aggravating gang? "In keeping with the prevailing social norm in America today, these parents were prejudiced against the Puerto Ricans," Mr. Mendes said.

"In Charlottesville," said Dr. Frank Curran, director of the Charlottesville (Va.), Child Guidance Clinic, "when we have gangs, when they break each other's glasses or jaws, it is the kids from the county high school versus the kids from the city high school."

These illustrations showed not only that there are situations where the parents play no part in their children's delinquency, but also that to be a "primary cause of" is clearly not always equivalent to being blameworthy.

Other illustrations heightened this conclusion. Dr. Harris B. Peck, director of the Bureau of Mental Health, New York City Court of Domestic Relations, told of a Negro woman who broke broomsticks over her child's back in an attempt to discipline him. When this 15-year-old boy was brought into court for attempted rape and robbery, his mother described him as a boy who literally had never spoken a "fresh" word to her before his adolescence.

In a discussion group for mothers held in the court she blamed her difficulty with him on the inadequacy of the relief allowance which made it impossible for her to live in a place where the children would have decent company or to give them money for the extra things they needed.

This woman said she tried to do everything to make her children happy. "But when it doesn't seem to be of any use at all, I just go out and I work and I work, and when the children are bad, I whip them, even though I know it doesn't do any good."

In this case, environmental and intrapsychic factors combined to produce a situation in which a mother, in outraged frustration, acted in a manner conducive to delinquency in her son.

In other cases, the parental behavior that leads to delinquency in a child may be proper behavior in the cultural group to which the parent belongs. Joseph Monserrat of the Migration Division of the Puerto Rican Department of Labor in New York told of a Puerto Rican woman who dragged her daughter away from a settlement house dance because of her belief that any girl who goes out with the boys is "no good."

"In one family you have two people who are absolutely right, depending on which value system you use," Mr. Monserrat pointed out. "The parent and the community are in a clash, and the kid is caught in between the two."

In still other cases the parents may be doing all they know how to prevent delinquency but without avail. Mr. Mendes told of meeting the father of a boy who had been taken to the hospital with serious knife wounds suffered in a gang fight.

"The father was pacing the hospital corridor, saying, 'What can I do? I beat him every night. I tell him not to go around with these kids.' "

All Economic Groups

The problem is not confined to one economic class. Out of experience as a counselor in a well-to-do suburban county, Edith P. Popenoe of the Montgomery County (Md.) Public Schools told of a conference with the parent of a 9-year-old emotionally disturbed child. "He fights constantly and children complain that he always gets them into trouble. The

father, a serviceman, expects instant obedience. The mother says that nothing the child ever does pleases him. She is somewhat of a perfectionist herself." Actually both parents are trying to do a good job, but the pressure of their high standards is causing the misbehavior, according to Mrs. Popenoe.

Blame is clearly not the word for it in such situations. However, it does not absolve parents from responsibility for doing a good job with their children, the conferees agreed. The question to be answered, suggested one, is, "How can we do something positive for parents in a way that does hold them accountable for their children's behavior?"

Would Punishment Help?

At the present time the statutes of most States contain provisions allowing the juvenile court to take action against parents, as well as other adults, who contribute to a child's delinquency.

However, bills are pending in some States that would put an absolute liability on parents for property damage by children, whether or not negligence on their part is proven. A discussion of these raised the question: Would laws inflicting automatic penalties on parents lessen delinquency?

William H. Sheridan, a social worker and lawyer on the Children's Bureau staff, maintained that to place that kind of legal responsibility on a parent is unsound, "legally and socially."

Dr. Peck maintained it was a paradox for a community to fail to provide the kind of outpatient mental-hygiene service that an emotionally disturbed mother needs and then to punish her for having failed to bring her child up well: "The community falls down and then uses the parent as the scapegoat."

Mr. Mendes upheld the legal structure of society but questioned whether retributive law could be a significant factor in decreasing delinquency. Pointing out that many boys become delinquent because of the pressure of high standards exacted by their parents, he predicted that laws automatically calling for the parents' punishment would result in the parents transmitting the increased pressure to their children. This, he said, could result only in "more antisocial behavior."

Bertram Beck of the Special Juvenile Delinquency Project associated with the Children's Bureau maintained that such proposals ignored cases in which the cause is predominantly social-cultural. He added that they were based on a misconception that parents will change under coercion. "It requires extensive, prolonged efforts to change people's behavior," he said.

Why, then, if the effectiveness of these newly proposed statutes is likely to be so slight, is there so much pressure for them?

Norman V. Lourie, executive secretary of the Association for Jewish Children of Philadelphia, traced them to "a kind of frustration about not knowing what else to do, because so little is known about the etiological elements in delinquency."

Dr. Donald Bloch of the Children's Psychiatric Service, U. S. Public Health Service Research Hospital, suggested that persons who work with delinquents may have fostered these demands, first by using alarm as a way of getting additional services for delinquent children, and second, by making too extravagant promises about their ability to reduce delinquency.

On the other hand, Mr. Lourie suggested that if social workers could become more confident in their own understanding and handling of these youngsters, their conviction would gradually get "rubbed off" on the public, leaving a general "feeling that these children can be helped and do not have to be feared."

While disapproving proposals for mandatory punishment of parents for children's delinquencies, the group agreed that law can sometimes be a valuable instrument for holding parents to their responsibilities.

Dr. Bloch gave an example of how a law permitting courts to take children away from parents helped

—Philip Bonn, Children's Bureau.

Juvenile courts in most States have authority to hold parents responsible for their children's delinquencies, but such authority, according to the conversations reported in this article, can be effective only when used with discretion and with careful consideration of all the factors in the individual case.

a child by making it possible for him to get needed treatment.

Robert C. Taber, director of pupil personnel and counselling, Philadelphia Public Schools, provoked discussion by describing his school board's action in prosecuting 666 parents on charges of neglect. He maintained that in 67 percent of these cases the child's school attendance improved. Prosecution, he added, had been confined to cases in which the parent was primarily responsible for the truancy, but was unwilling to do anything about it.

"We use authority in what we think is a constructive way," Mr. Taber said. "For instance, when a youngster is flagrantly absent, we will have a juvenile-aid worker go to the home, get the youngster out of bed, and take him to school."

Dr. Peck declared that he would be opposed to that procedure for certain groups. He spoke of some Puerto Rican parents who are undoubtedly contributing to truancy and said that he doubted the value of forcing a 15-year-old boy who cannot understand his teacher's language to go to school when his mother needs him to help support the family.

Mr. Taber explained that in Philadelphia if the parents are handicapped, or the reasons for truancy are beyond the parents' control, they would not be prosecuted.

"You have to look back of each situation," he said. "For instance, if we see something in school experience that is bad, we may arrange for a school-work program." He told of a group of children with "no academic motivation" whose attendance rose above the school average after they were placed in a class where they work half time.

He agreed that authority should never be used to shunt a child into something that is not adapted to his needs.

Ruth Kotinsky, formerly assistant director of fact-finding for the Midcentury White House Conference on Children and Youth, referred to a New York study which indicated that improvement in school attendance was less marked among children whose parents were fined after court action than among others. She suggested that the difference in the Philadelphia experience might be in the careful selection of parents for prosecution.

Carl Schoenberg, director of casework services for the Association for Jewish Children of Philadelphia, said that while there have probably been some instances in which court action against a parent had facilitated getting the child into a program of treatment, in other cases court proceedings had not helped.

Dr. H. B. Moyle, psychiatric consultant to the Connecticut State School for Girls, said that in his observation whenever a severe punishment was administered by the court, the child was almost invariably hardened against the court, the judge, and anybody else who wanted to help him.

Mr. Taber, on the other hand, said he had seen a family constellation change entirely after a court experience.

He cited a case of a "pipsqueak" father and a highly neurotic, dominating mother. After court action the father took hold in a masculine way and the boy, who had been stealing, running away, and playing truant, began to make an excellent record.

"A lot depends on how it is handled," he explained. "Fortunately, we have counselors in the schools who are able to handle the hostility that court action usually generates and can help make the court experience a constructive one."

In the subsequent discussion two points were stressed about this careful use of court action: that it is comparable to other methods used by social workers to reach irresponsible parents; and that its goal is to hold parents to their responsibilities rather than punishment.

Mr. Taber maintained that "authority is very important, but it must be discretionary and it must be used on a selective basis."

Some Other Approaches

Discussion turned to parents who are not indifferent to the delinquency of their children. The main focus was on methods of working with them and on obstacles to effective work.

The usefulness of the group-discussion method received considerable attention.

One way to get at parents, said Dr. Margaret C.-L. Gildea, St. Louis psychiatrist, is through parent education in child rearing and mental health, carried on through discussion groups led by parents who are from much the same cultural setting as the parents who are in attendance. Another is through group discussions with parents of preadolescents who have been identified by teachers or other school staff as potentially delinquent. Dr. Gildea told of how in St. Louis such parents are invited to come to the school and then are brought together into therapy groups for discussion of their problems in child rearing. After a few sessions of blaming the school, the parents begin to recognize that the problems their

children are exhibiting in school are related to what is happening at home, she said.

While this program was successful in some areas of St. Louis, in others parents could not be induced to attend the sessions. The outstanding failures were in Negro districts, where there is a distrust of any authority, and in more prosperous suburbs "where parents won't come near the school."

Dr. Peck told of his experience with therapy groups for parents in the New York City courts. These were first set up for parents for whom individual treatment had been ineffective—parents who didn't want to talk to a social worker or psychiatrist about their role in relation to their children's delinquency. He told of how after they had been allowed to air their grievances against the schools with each other "they were able to consider their own role in their children's difficulties." About half the mothers showed some degree of progress after these sessions, he said.

The conferees indicated that casework and individual psychotherapy also each has a part to play in helping parents deal with delinquency.

Alice Overton, a New York City social worker, maintained that more of a "reaching out" effort must be made by social-casework agencies which usually "sit back and . . . insist that the parents must be able to ask for our help."

Clifford Shaw of the Institute of Juvenile Research, Illinois Department of Public Welfare, agreed that "the delinquent is largely outside the pale of the whole range of social agencies." He said that in child-guidance clinics the trend has been away from delinquents to middle-class and upper-middle-class children.

Dr. Bloch said that this is a trend all over the country. "There isn't a clinic or an institution . . . that isn't becoming greatly interested in childhood schizophrenia and the neuroses of the middle class," he maintained. They find that they can really get somewhere with such cases and so they are giving up treating delinquents."

On the other hand, Dr. Curran thought policies varied with the philosophy of the people in the clinics. At the Charlottesville clinic, where 80 to 90 percent of the patients once came from the middle and the upper economic classes, 60 to 70 percent now come from the lowest economic brackets, including many referrals from the welfare department or court. Both social workers and low-income clients, especially Negroes, have to be convinced that the clinic can help, he said.

Mr. Shaw, originator and director of the Chicago Area Project, described its approach to the delinquency problem. This is based on the theory that delinquency in slum areas is largely a by-product of deterioration in social relationships and lack of social cohesiveness; hence the project's efforts are directed to the community. He pointed out that "in urban

—Peter Sekaer for Federal Public Housing Authority.

—Murphy, Chicago.

Society, too, can be at fault, as when it tolerates the kind of slum pictured on the left. But even in poor neighborhoods, if conditions are not too deteriorated, parents can get together to provide constructive experiences for their children as have those shown on the right helping their boys clean a vacant lot. They were encouraged to these efforts by the Chicago Area Project.

slum areas a lot of children become involved in a way of life in which a premium is placed upon skill in committing delinquency."

In such blighted areas the usual philanthropies in which "people in privileged circumstances" decide what the others need are ineffective, he maintained. Therefore, he said, efforts have to be made to use "the greatest potential available," the organized effort of the people who live in those areas.

Mr. Shaw told of how the Chicago Area Project has helped neighborhoods to organize themselves for action in regard to the welfare of children—to set up recreational and educational programs, to engage in various sorts of community action, and to work with individual delinquents.

The project employs "marginal persons"—former delinquents or persons who have lived close enough to delinquents to have some sense of how they feel. These persons get in touch with delinquent youngsters and provide them with a link to conventional society, thus helping them to become incorporated into a constructive social group.

Not regarding these various approaches to delinquency as antipathetic, the conference pursued the question of their integration and mutual support.

Dr. Peck observed that while efforts toward "enabling parents to join together to deal with some of the conditions that thrust them and their children into pathology" were relevant for delinquency prevention, some of the "maladjusted parents" of delinquents might need therapy before they would be able to participate in community action.

Miss Overton pointed to the need for a bridge between measures for collective action and efforts at motivating parents to do something about their own problems. Mr. Shaw suggested one:

"What I would like to see in an area with a high concentration of delinquency would be a psychiatric unit sponsored and operating in a united way with the whole range of social agencies and with the organized residents," he said.

Obstacles to Effective Work

Frequent references occurred throughout the discussion to attitudes and situations that handicap work with parents and children, some of them within the helping professions themselves, others in the environment in which these professions work.

The conferees agreed that poverty and its attendant miseries cause such exasperation and frustration in parents as almost to preclude treatment efforts aimed at improved parent-child relations.

The Chicago Area Project helps parents attack juvenile delinquency by working together toward specific goals to make better opportunities for their children. Here parents are attending a neighborhood committee meeting.

Several conference members cited school conditions so unfavorable to children's development that parents could scarcely be expected to encourage attendance or attention to studies—schools "where there is a jungle of distrust between children and teachers, teachers and parents, principals and teachers."

The attitudes and practices of some juvenile courts were also deplored. These included some judges' personal prejudices and the callousness or indifference of others.

On the other hand, other psychiatrists told of courts that give careful attention to the needs of children and their parents.

Psychiatrists themselves do not always serve courts adequately, Dr. Curran held. Closer relations between psychiatrists and judges and between psychiatrists and probation officers are obviously needed if delinquents and their parents are to be well served, he said.

Dr. Peck reminded the conferees that judges have a different function to perform from that of social workers and psychiatrists—"to protect the family and children from, among other things, psychiatrists and social workers, so we don't go plucking children out of their homes without regard for the parents' constitutional rights."

On the other hand, some of the conferees cited the advantages of constructive relations between judges and court clinics. A psychiatrist pointed out that though the information furnished by the clinic has no bearing on whether the child did or did not commit a delinquent act, it may help the judge decide how to dispose of the case.

The shortage of treatment facilities and inadequacies in their services were also named as obstacles to combating delinquency.

Dr. Curran pointed out that there are less than 10 psychiatric clinics attached to juvenile courts in the entire United States, that thousands of courts have to refer children and their parents to hospitals or city clinics often miles away when they want psychiatric opinion. Since these courts usually have no trained probation officers the teamwork approach between judge, psychiatrist, and probation officer cannot exist.

Mr. Lourie cited the scarcity of facilities to care for delinquent children.

Mr. Taber said that the shortage of court staff in Philadelphia had resulted in an average delay of 9 months between arrest and hearings. This results in the court's ignoring many violations of probation, thus abetting the children's delinquency.

The attitudes and practices of the professions that supply services to delinquents also present obstacles to effective work, according to the conferees. Their comments emerged from a kind of soul-searching on the part of devoted practitioners rather than any attack on the professions' work.

Mr. Lourie maintained that in many areas the question is not whether to build new facilities but how to make proper use of the ones we have.

"Many of our children's agencies have rejected the kind of children and the kind of parents we are talking about," he charged.

Miss Overton condemned "our premature and ill-considered taking of children out of their homes on neglect charges, without any serious attempt to strengthen family life." This and a tendency to brush aside the parents' descriptions of their burdens she saw as arising from a lack of respect for parents.

Dr. Bloch suggested that social workers and psychiatrists "want to treat everybody with love," and therefore have trouble with their own use of authority, not only in dealing with delinquents but also with parents.

Mr. Shaw said that labeling children as delinquents put barriers between them and their parents and conventional society. "The problem of rehabilitation is to find out how we can bring these outcasts back into some kind of significant relationship to the rest of the community," he said.

Miss Overton spoke against the tendency to regard as hopeless, parents who will not come for services. She also maintained that it was an error to conceive of social action as something quite separate from work with the internal factors of a family or individual. Defects in the social mechanism which help to pull families apart can be acted on in the day-to-day job, she said.

"We don't have to pass a law or change a whole community. . . . Maybe we can go to one school and persuade teachers who have been prejudiced against a whole family of kids to write positive reports, or to give little words of encouragement," she suggested.

The conferees recognized another obstacle to preventive therapy in the fact that delinquents cannot be identified until they have committed offenses. They can be identified as deprived people, however, said Dr. Bloch, who pointed out that this is their "hallmark" whether from "upper middle-class, middle-class, or lower-class families."

Deprived people, he added, need some kind of support—whether individualized psychotherapy or the payment of a grocery bill.

In Summary

While the conference did not result in formal conclusions, a statement prepared by Mr. Taber toward the end of the meeting seems to summarize much of the group thinking: Said he, in part:

"The recent barrage of criticism against parents as being wholly responsible for juvenile delinquency is unfounded. To be sure, parents are the primary source of a sense of responsibility and respect for law and order in their children. To the degree that there is warmth, stability, and harmony in the family, to that degree children will have a sense of well-being. . . .

"One thing is paramount, that we hold our children accountable. To do otherwise is to do them a disservice.

"We cannot, however, in good conscience, hold parents wholly responsible for delinquency as long as there are wars, or fathers are in the armed services, or on night shifts, or when divorce is so frequent. Parents are also caught in cross-currents when courts are delayed in hearing cases, when truancy is not considered a violation of probation, when social workers' caseloads are so high that no effective followup is possible, when intake at guidance clinics is shut off, when admission to institutions for defective delinquents is delayed unduly, when resident centers for psychiatric care are practically nonexistent.

"The problem of delinquency has many facets and no one group can be singled out for blame. . . . As parents and community, we are jointly responsible and must join forces to meet the problem on a broad basis."

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Michael Reese Hospital in Chicago combines therapy and training in . . .

A NURSERY SCHOOL FOR CEREBRAL-PALSIED CHILDREN

LOUISE G. YUM, M. S.

Director, Therapeutic Nursery
Michael Reese Hospital, Chicago, Ill.

THE MICHAEL REESE HOSPITAL nursery for cerebral-palsied children, established in 1944 as an experimental and demonstration center, provides a social, educational, and treatment program for 14 handicapped pre-school children.

A cerebral-palsy clinic open to children of all ages developed as an outgrowth of the nursery. It provides medical supervision and specifications for equipment and takes responsibility for referring patients to treatment programs, but has no therapy program of its own. The nursery center includes the nursery proper and a treatment section with physical, occupational, and speech therapy.

In the nursery proper the fundamentals of a good nursery school are adapted for the chilld with a physical handicap so that the program can provide opportunities for him to function and develop to his maximum ability at his own speed. Each day's activities require some special planning for each child because of the multiple handicaps presented by cerebral palsy. If Jamie cannot walk he need not be relegated to one location for long periods but can be taught to crawl or ride a bike, or helped to tumble with the more hardy children on the mats. Davie or Susie can join the group at crafts if given a sponge instead of a brush with which to paint. Each child receives the dramatic equivalent of some activities he may not directly experience because of his handicap.

The school has a well-trained and flexible staff of teachers and assistants, therapists, and a social worker, who help the children and their parents as a cooperating team. Medical specialists in the treatment center provide highly specialized medical care and consultation for defects in hearing, vision, respiratory function, mental retardation, aphasia, and other handicaps which may accompany cerebral palsy. An administrator coordinates the services of physicians and training staff into a secure working team concerned primarily with the welfare of each child and his family.

Activities

The children spend a major part of their time playing, because this is the way they learn, create, share, and mature. However, unlike many nurseries, Michael Reese does not segregate children into age groups. The teacher sets the stage for all kinds of activities adjusted to the ages and current interests of the children and their previous play experiences as well as their handicaps. She encourages the badly handicapped child who cannot walk to achieve experiences as near the normal child's as possible by showing him how to use special apparatus or teaching him to roll or crawl. She listens to the boy or girl who cannot speak intelligibly and gradually learns to understand and communicate with him. She encourages the confused child who refuses any patterned toys to create with paints, clay, or sand. She tries to be sensitive to each child's wishes at the moment as well as his needs in the long run.

Like any well-planned nursery the Michael Reese Nursery provides the children with four important

areas of experience: free play; group activities; regular routines; and special occasions.

Since preschool children work best in small groups of two to five, they need a program allowing each to get about on his own, choose his activity, play freely alone or with several others, and change to something else as his interest and attention span demand. The teacher sets the stage, indoors and out, with a variety of interesting toys and creative experiences. Some children ride together on built-up tricycles or specially adapted walkers, pushing a weighted doll buggy, descending the safety-rimmed slide, moving up and down a set of bannistered stairs, rolling on mats or crawling up the incline, or in some other way getting that gross motor activity so necessary to every young child. Another child lies flat on the floor, running small cars over the surface around him. Some children play "tea party" in the doll corner or load groceries in the school store, while others take an imaginary boat trip with lined-up chairs. One "reads" the pictures in a book.

Throughout the period the teacher guides and encourages each child according to his needs or sets limitations understood by the children themselves. Without neglecting anyone, she devotes special time to the badly handicapped child, helping him achieve a well-rounded day of play and group experiences.

Because they lack some of the normal child's experience, young cerebral-palsied children usually need more definite information and direct guidance to orient them to the outside world and to stimulate creative play. The cerebral-palsied child may never have gone shopping with mommy or bought a newspaper with daddy or mailed a letter. He may have to be taken on a trip to see the trains or to be shown pictures of them before he will "play train" or attempt to draw one. Planting seeds, baking cookies, washing doll clothes are experiences which make books seem more realistic. The group of children around the craft table or in the block corner will need varying amounts of help but each child can initiate some part of his project to make it his own.

The nursery uses a variety of medically approved and individually adapted means of assisting a handicapped child to stand and move about on his own. Because a handicapped child resents being set apart by having to use a table or wheelchair the regulation nursery chair, with additional support built under competent supervision, is used for every child in the school. The conventional stand-up table, or the individual chimney support where a table is not needed, enables the child to be located near any toy or piece of equipment he chooses. Toys are carefully selected not only for durability and adequate function, but for continued interest and possibilities for growth. Blocks, puzzles, and formboards, patterned toys of all kinds help develop eye-hand coordination and recognition of color and shape. Packing boxes, boards, and mats provide opportunities to climb, jump, slide, or crawl in and out of something. Toy cars, boats, dishes, dolls, and animals set the stage for dramatic play.

Over a period of time, noticeable changes take place within the group. Children new to the nursery play mostly by themselves or grouped about the teacher, and rarely settle down to anything for long. Several months later, however, they enjoy more highly organized forms of activity. Two children playing together run trucks side by side or briefly enjoy a party or house play. Several sit around a table building a garage together or planning a bus or train trip with nursery chairs. The children have chosen friends, and are beginning to exhibit signs of community spirit.

Although the children spend much of their day in

At the Michael Reese Hospital Nursery for Cerebral Palsied Children a physical therapist works with each child according to his special needs. Here a child is learning to walk with a brace.

free play, some part of it is occupied in a teacher-directed group. Every day before lunch the staff groups them into younger and older sections for music, stories, and conversations. The younger ones learn to attend and to participate for short periods in very simple songs, games, or accounts of their doings at home. They may plant a seed, watch and talk about the ways of the pet turtle, or illustrate a song with simple movements or gestures. The older ones participate in prereading experiences. They note birthdays on the calendar, look for "long" or "short" or "round" objects in the room, talk about books and learn to look at them, notice signs and learn what they mean. They may present an oral "newspaper," plant a garden, or plan a special event, such as building a drugstore with packing boxes. Such participation helps develop attention, self-expression, and group planning.

Special occasions include birthday celebrations, holidays, and seasonal events. A timid, handicapped child may bloom first at his own birthday party where he is the center of attention in a pleasant setting. The children may spend days getting ready for the annual Christmas party for parents, making gifts for Mother's Day, or baking cookies for some occasion. Periodic trips to a farm or the zoo, or a market or business center, initiate all kinds of creative art, lively discussion, or imaginative construction.

Routines

In every nursery school the staff helps the young child to learn to handle his natural requirements—the general routines of eating, sleeping, toileting, self-help, and cleanliness—by patient guidance, without pressure, after carefully watching for cues that he is ready to assume responsibility. The cerebral-palsied child usually needs extra help not only in the use of some special equipment but also in achieving a measure of self-help and independence.

Daily after lunch and nap the children at Michael Reese sit near their beds dressing and undressing. Their teachers and therapists without any nagging or punishment encourage them to take off and put on wraps, lace and unlace shoes or manage braces, and use their own cups, forks, or spoons at table, alone or with the amount of help needed. The presence of other children also provides them with a strong though indirect social suggestion toward self-help.

As in other nursery schools the staff at Michael Reese helps the child understand and accept conformance to routines and certain standards of behavior such as sharing, recognition of the rights of others, and respect for property. Kind and flexible in placing limitations on a child, the staff members try to help him build up his own self-control.

They did this with Jennie. A passive, fearful child who spent most of her time alone, Jennie refused to wear her new body brace. Without any attempt at force, the physical therapist talked to her kindly about the brace and its use. After several days she quietly said to him, "Mr. John, I want to have a secret with you. When you take me on my trip tomorrow I will wear my brace for you." And thereafter she continued to wear it.

The Working Team

The friendly working relationship among staff members at the nursery center is sensed by the children as well as by visitors. A well-defined working policy results in effective teamwork on overall problems and the problems of individual children.

The physical therapists in the nursery emphasize posture and locomotion not only through table work but in helping children use apparatus, carefully designed to meet the needs of each. The physical therapist also works with the teacher on plans to further the developing abilities in the group. These may involve a more active nursery program for the severely handicapped, including such activities as mat rolling, crawling, and the use of a specially adapted walker, tricycle, sliding board, or chimney support. Such activities prevent contractures and other liabilities due to continuous sitting or inadequate posture, bracing, or ambulation equipment. The physical therapist aids the individual child in a variety of ways, from helping to make him physically comfortable in his chair, periodically evaluating the amount of mechanical or human support he needs in walking or sitting, or helping him to acquire a new ability such as bike riding.

The speech therapist helps the child learn to talk or improve his speech in a treatment session and during his efforts at spontaneous expression in the nursery group. When her time allows, she cooperates with the teacher during the conversation and music periods or unobtrusively joins the children in free play around the sandbox or tea table, talking with them informally and evaluating their communicable speech. Her conversation with shy Teddy as she helps him dress after nap may be as beneficial as any direct "lesson."

The occupational therapist centers largely on

Learning how to dress themselves, a difficult task for most palsied children, is an important part of the nursery program.

developing the child's independence in feeding, toileting, and dressing through direct function or indirectly through toys and games. Being present to help certain children take off their wraps on their arrival, she promotes hand function and encourages self-help. Her aid to Sandy at lunch may be as valuable as any "feeding" session in the treatment room.

At times the occupational therapist and teacher plan certain projects together such as finger painting, doing puzzles, or whipping cream to make butter. In this way the therapist not only helps certain children needing specific aid but encourages correct hand usage throughout the group. She also helps children individually—little Susan to keep her hands flat while finger painting, Dale to use both hands by building with large hollow blocks, Donna to use the left hand to assist the right. In her work during the children's activities she is careful not to dominate the group nor destroy its spontaneity. This work does not require her daily attendance in the nursery group nor a sacrifice of her own program of individual treatments, but it does enable her to use the daily nursery program to further her own efforts.

The nursery's social worker helps the parents understand the nursery's activity and treatment program in relation to their own children. She also helps them with their personal and family problems. In addition she confers with other staff members, in meetings and individually, in an effort to bring about more effective coordination of the child's home and school experiences.

The teachers at the Michael Reese nursery are selected not only for their background in child development and techniques in handling young children but also for their warmth and friendliness. Their job requires encouraging the children to express their feelings, pleasant and unpleasant, and to accept the unpleasant ones. They help the children redirect their hostile expression into acceptable channels, and in the long run, to grow into acceptable behavior. They do this not by nagging or scolding but by analyzing each child's particular problem and attempting to help him grow on the basis of his needs.

For instance, instead of reproaching listless, badly handicapped Martha for her continual wetting, her teacher and therapists set about helping her to hold her own cup, feed herself with a special spoon, ride a tricycle, color and paint in her specially built chair, and play with the other children. In time she proved to be one of the most imaginative children in the school. As her happiness grew, the teacher explained to her how she would try to help her keep dry. Soon after this, Martha stopped wetting.

The teacher at Michael Reese helps the children build up wholesome attitudes toward their own bodies. She handles their questions about differences in sex or their "crippled" condition openly, casually, and reassuringly, yet realistically. She provides opportunities for the child's social adjustment, helps him maintain his own rights and feelings and respect the rights and feelings of others. While she is not at the hub of all activities, there are times when she

Most children love to play telephone, and at the Michael Reese Nursery this play becomes a useful part of speech therapy.

must guide or intervene. At other times, after carefully setting the stage, she retires somewhat into the background to watch and listen. She adapts the daily program, supervises her assistants, evaluates each child and his progress, and works with each according to his needs.

One of the most difficult problems faced by the teacher of young cerebral-palsied children is how to concentrate attention on the needful child yet spread her energies over the group. Judy, who cannot put a puzzle together, pick up the crayons as she draws, or accomplish any hand function alone, must have special attention. But the teacher must also attend to the group as a whole, redirecting children temporarily bored or steering them into some purposeful activity, quieting the boisterous ones before rest time, helping plan a particular craft project, protecting certain children from their aggressions, and performing a variety of other services.

The teacher must be careful, however, not to force the child who flits from one choice to another, unable to settle into any pursuit, into some purposeful activity before he is ready for it. He may be too disturbed to play constructively or he may have had no previous experience with other children or with play materials. He will need gradual encouragement.

The nursery teacher at Michael Reese is interested in the children as developing personalities and not as "cute little darlings" to be exploited or merely played with. Sensitive to the difficulties of the immature child with little social experience beyond the mother-child relationship, she helps him bridge the gap in forming other relationships. She encourages shy children to express themselves and to take their own part and tries to protect the aggressive ones from too much guilt over their attacks. She guides each child according to his stage of development.

Parent-School Cooperation

The nursery's physicians and training staff, with the help of the social worker, work individually with parents to help them further their children's development. The therapists teach the parents how to apply and care for braces or how to help the child use some ambulation equipment or a built-up spoon to feed himself. They encourage parents both to talk and to listen to their child, thus furthering his efforts to communicate. The teachers encourage parents to widen their children's experience by taking them on trips to the park, the firehouse, a parking lot, a farm or a store, thus giving them a background for understanding the world in which they live.

Parents are encouraged to visit the center to observe or to talk over problems with teachers and therapists. This not only furthers their understanding of the nursery's aims for their child but also provides the school with helpful information. Parents also are invited to carefully planned medical reviews, where they can talk informally with physician and staff about their child's progress.

Every spring and fall informal workshops bring staff and parents together to mend, paint, and decorate books, toys, and furniture, and generate a feeling of friendly cooperation. In addition, fathers and mothers meet once a month with the director for parent-centered discussions. She encourages them to express their feelings and helps them make suggestions for resolving their own problems.

Does It Help?

Each child admitted to the nursery is carefully selected from the applicants with an eye to all his needs and his likelihood of benefiting from the program. The parents' ability to cooperate is considered as a factor in the child's potential success or failure.

After the nursery accepts a child, the social worker helps prepare both mother and child for what may be their first separation. Mothers attend school for the first week or more to help their children in their initial adjustment. Well in advance of a child's discharge from the nursery the social worker plans with the parent for his future, taking into consideration the child's abilities, his family's wishes, and the opportunities available in the community for his education and training.

How do we know whether the school has helped the child over the months or years? There is no exact formula, of course, only certain clues, for evaluating a child's growing maturity. As we live with these children and care for them day after day we compare each one's growing maturity with his past behavior. Is he increasingly happy and outgoing? Is this dependent little boy becoming more self-reliant and successively able to direct his own activities and interests? Is he more resourceful in solving his own problems with less appeal to the adult for help? Is the retarded or confused child growing more interested in colors and shapes, objects and experiences in the world around him? If a child is developing in some or all of these ways, if he is becoming more creative and imaginative, with ever-growing and more mature interests, he is probably advancing on a par with his possibilities. No nursery school can expect more.

Plans to bring "orphans" from abroad call for consideration of...

PROBLEMS OF INTERCOUNTRY ADOPTIONS

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DURING RECENT YEARS a number of studies[1] have been made to collect comparative information about child-care and adoption practices in various countries so that the national experience in this field could be shared. Unfortunately none of these studies have included information about several of the countries from which so many of the children we know are coming or will come under the Refugee Relief Act—Germany, Austria, Italy, the Far East. Nor has any part of what we may now call the "international literature" been devoted to the intercountry adoption in itself.

How could it be? This is such a recent phenomenon—at least on the large scale to which it has grown—that we have no systematic experience upon which to draw. We do have right here in the United States, however, a good deal of very recent raw material as a result of the programs for unaccompanied children under the Displaced Persons Act with which the U. S. Committee for the Care of European Children and some of the sectarian resettlement agencies were concerned. There are also the many adoption placements initiated privately by American families and which at one stage or another come to the attention of child-welfare agencies and of the International Social Service. We have learned some lessons and perhaps we should begin to draw conclusions.

Some questions naturally come to mind first. Is the number of intercountry adoption placements so significant and are the factors involved so special as to warrant concern? Does the situation really call for reconsideration of our traditional casework methods of child placement and perhaps for a redefinition of our respective areas of activity as social agencies?

The International Social Service from its vantage point of accumulated experience in working with child-welfare agencies across the United States and in many foreign countries, has observed that the number of children coming to this country is steadily growing; that most agencies here and abroad are increasingly aware of the special factors involved; that whether or not we are always conscious of it, the traditional scope of many agencies has broadened to meet the demand for service; that a good deal of thought has been given to the ways of adapting accepted child-placement procedures to intercountry situations; and that to their own surprise, some caseworkers have discovered the use of what we may call long-distance casework—in other words, the use of their basic concepts and skills without necessarily establishing direct relationship with all the persons concerned: the child. the natural parents, and the future adoptive family.

Prevalence

Adoption cases and inquiries coming to the attention of International Social Service represent but a small part of the general picture, yet they reflect the steadily growing interest of American families in adopting children from other countries. Various types of adoption cases and inquiries coming to the American Branch of the International Social Service totaled 58 in 1951, 220 in 1952, 464 in 1953, and 346 in the first three months of 1954. This means that in 1952 the number of adoption cases was almost 4

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times as large as in 1951; in 1953, 8 times as large as in 1951, and if the trend continues at the same rate, it is likely that the number of inquiries in 1954 will be 23 times as large.

There is no total figure obtainable of children who have come to the United States for adoption under various Government or agency programs. But the data available, although overlapping and incomplete, is useful. The final report of the Displaced Persons Commission gives a total number of 4,182 visas issued to children brought to the United States for adoption and guardianship under the Displaced Persons Act. The more recently enacted Public Law 162 provided 500 special immigration visas for children adopted abroad or to be adopted in the United States by military personnel and civilian employees. The Refugee Relief Act makes provision for 4,000 special visas outside the quota for certain "orphans" adopted abroad or coming here for adoption. "Orphans" under this act may be children with one parent or under certain circumstances both parents, still living. While such special legislation concerns only certain children coming from countries where the immigration quotas are oversubscribed, other children born in countries where the immigration quotas are current or only slightly oversubscribed continue to come under the regular immigration procedure. Their number cannot be readily estimated.

It is clear that the children who in recent years have been coming from different countries for adoption must be counted by the thousand. It is also clear that as long as the number of families seeking children continues to exceed the number of children available here, there will be public pressure on Congress to pass new legislation facilitating the admission to the United States of foreign children for adoption. Perhaps it is not surprising that in this country of people coming from various national and cultural backgrounds, many a person should turn to the country of his own origin when seeking a child. Real or imaginary cultural affinity, certain physical traits familiar since childhood, make for a strong emotional bond.

Adjustment

There is no common pool of data regarding the adjustment of foreign children adopted in the United States or the incidence of serious difficulties found among the total number of children brought to this country under various programs.

The final report of the United States Committee for the Care of European Children published in 1953 points out that on the whole the 4,000 unaccompanied children brought to this country under its three programs have presented no more problems than American children who were deprived of affection and suitable homes during their earlier years, and that their adjustment was actually easier than most child-welfare agencies had expected. However, most of these children were not selected specifically for adoption but came to the United States for care of some kind because they were displaced from their own country and needed special assistance.

The caseload of the International Social Service may not represent a true picture of general adjustment for the simple reason that many cases come to our attention only when there is some impediment to adoption or when emotional difficulties arise. Our records show, however, that of 185 children who arrived in this country under individual or agency arrangements between June 1952 and December 1953: 106 have been legally adopted; 54, in the process of being adopted, present no special adjustment problems; 2 must await clarification of legal complications; 8 experienced adjustment difficulties which were resolved through replacement or casework service; 15 are still having difficulties in adjusting. Ten of these 15 unadjusted children are blood relatives of their adoptive parents.

Problems

Granting the special needs of stranded children, many social workers have raised the question of why, when there are obvious hazards in intercountry adoption, the parents and the guardians of many children allow them to be placed outside their own country. There is probably no single answer covering each case but there are a number of general answers: limited economic conditions, overcrowded institutions, the large number of illegitimate children, and the overall assumption that the child will benefit by better opportunities in the United States. This assumption is sometimes so strong in the minds even of experienced social workers in other countries, that any questioning of it by some of us here is considered unreasonable.

The opinions of social workers are divided, however. Some social agencies abroad have serious doubts as to whether in the long run it is beneficial for a child to be removed from the whole of his traditional surroundings. However, the pressure of American families seeking children is one element

which should not be discounted, nor should the efforts to obtain children from foreign institutions made by public officials, lawyers, ministers of religion, and others acting under the conviction that adoption in the United States is the best solution for most children. When these pressures are combined with the fact that many of the illegitimate children are fathered by American servicemen, both white and Negro, and that these children are often different from other children in their home communities and not always accepted by adoptive parents there, it is not surprising that adoption in America may be regarded as the obvious solution.

Out of this background picture we may isolate the special factors in intercountry adoption which intensify the problems inherent in the more usual adoption of a child. Actually these basic factors are self-evident; geographical distances between the people concerned and between the agencies working on the same case in different countries; differences in the general conditions of life and in the social structure in the countries concerned; differences in cultural attitudes, especially toward adoption. Of course these factors affect the casework services and the application of agency practices developed to meet the needs of a local community.

The problem of the release of her child by the mother is a first consideration. The basic question of whether she really wants to keep her child becomes too easily obscured by the seemingly paramount factor of the opportunities she feels she may deny to her child in keeping him with her when she knows there is a possibility for him to go to America. The confusion resulting from this may and does lead to serious complications, which may be prevented if counseling service can be made available before the mother decides to sign away her child to people whom she has never seen but whose attorney or friend presses her to complete the arrangement through proxy.

In so-called "family adoptions," in which relatives arrange for the child to be sent to the United States, again the idea of material and educational advantages often dominates other considerations. While blood ties and a common cultural background can be strengthening factors in an intercountry family adoption, in these cases confusion often arises for the child as to his actual status and parentage. The family adoption planned without skilled advice may be particularly complicated when the meaning of the adoption itself is not the same in the two countries

In Europe, as elsewhere, children may receive loving care in institutions, but it can never be the same as in a home of their own.

concerned. In many instances the natural parents abroad think only in terms of material security and better physical care and, in keeping with the cultural pattern or the laws existing in their country (France, Greece, Italy) do not intend to sever legal or personal ties with the child. The American relatives offering to take a child, however, are likely to be influenced by the attitude towards adoption prevailing in the United States and insist on having the child as their own.

In the adoption of older children a special factor to be considered is the significance for the older child of the separation from those close to him in his own country when he comes to his new home with the feeling that he has been sent to America to benefit by better circumstances, leaving behind relatives or

The transplanting of older children is apt to be complicated by existing emotional attachments and fears of the unknown.

friends who must remain in less favorable conditions. The emotional implication of separation for such children certainly calls for special understanding and for interpretation to foster parents. The separation of brothers and sisters old enough to have formed strong ties needs special scrutiny when it is likely that the separation is irrevocable and that they will spend their lives far apart. The vexed question of age at which children might be placed for adoption becomes further complicated by the fact that an older child may have deep roots in his own culture. He may need advance preparation to become acquainted with the new language and customs, and special help upon arrival in a strange country.

The difference in socioeconomic conditions and in cultural patterns calls for consideration of the total picture in the child's own country and in the country of adoption in order to weigh alternatives for his future. A striking example is the special effort made by some groups to arrange for the adoption in the United States of half Negro children born abroad to German or Japanese mothers who are unable to keep them. The question as to what future such a child could expect in his country of birth where there is no stable Negro community and where his illegitimacy is patent, weighs heavily in the balance against taking too rigid a view of the standards to be applied in assessing the suitability of the adoptive home offered in this country. Such assessing can only be relative, within the total context of the opportunities for good care and the socioeconomic conditions to be faced by the child in his own country immediately and in later life, as against conditions in this country and the possibilities of becoming an accepted part of an accepted group.

The geographical distance between countries affects arrangements for the trial period in adoption. While it is undesirable that a prospective adoptive family should commit themselves irrevocably before a satisfactory period of living together with the child, it cannot be denied that a trial period outside of the child's own country presents complications. The trial placement itself has all the appearance of finality for the child who has crossed the ocean to join the foster parents. It is more difficult to remove and try to replace a child whose foster parents have invested so much emotionally and financially into bringing him to their home. The supervision of the child and casework counseling by a social agency that has no statutory obligation to provide it is not always acceptable to the parents unless they agreed to it prior to the child's coming. Needless to say if the original placement does not work out, and if a replacement cannot be arranged in this country, the return of the child to the institution abroad from which he originally came is a painful experience.

Geographical distances between the countries, necessitating as they do time-consuming consultation and exchange of information, also delay the actual placement of the child after he has been found and selected, as do immigration requirements. This delay intensifies the usual impatience and anxiety of future adoptive parents. In their eagerness to establish finally their rights to the child they are likely to complete the adoption by proxy, especially since a child adopted by American parents may benefit by a special or preferential immigration visa. Perhaps this problem calls for social action in the countries concerned to stimulate sounder adoption and emigration and immigration procedures. In the meanwhile much damage may be prevented by timely and expert counseling of families who seek children abroad and who often do not know that advice may be available from their local agency.

Cooperation

The recent years have brought an impressive progress in international cooperation on behalf of children between agencies here and abroad, even though they are operating under different conditions at different stages of development in social welfare programs. Special governmental schemes such as the Displaced Persons Act or the Refugee Relief Act specifically call for the service of social agencies in the selection of children abroad, for studies of homes and supervision until adoption takes place. Private arrangements to bring a child to this country also come to the attention of social agencies at one or another stage of development of the case. Sometimes the child has not yet been definitely selected. Sometimes the family already has in mind a particular child, who may or may not be a relative. It is generally believed in the child-welfare field that since private placements often tend to emphasize the interest of adults rather than of children, placement with the help of agencies is safer for the child. The need for safer procedures is particularly true for intercountry adoptions.

It is clearly insufficient for the protection of the child and the adoptive parents for them to have only the help of the agency or the institution in the child's country.

Numerous State departments of child welfare and voluntary agencies here have been offering service

in such private arrangements: to make home studies; to suggest what type of child would seem most suitable for the particular family concerned, and to provide supervision upon the child's arrival. Naturally agencies in each country tend to apply to these international situations the methods they have developed for local use when the same agency has the opportunity to study the child and the family, to supervise the placement, and to see to it that appropriate legal steps be taken in time. In this country, of course, some experience has developed in adapting local practices to interstate adoptions involving several agencies consulting each other and dividing responsibilities.

The part of the International Social Service in adoption has been to create a link between agencies in different countries operating in different cultural settings. This international cooperation works both ways—in behalf of children brought to this country and in behalf of American children placed or to be placed with families who were living in the United States but had to go to another country before the completion of the placement or adoption here.

Such cooperation between agencies in different countries not only helps individual children, but produces an important byproduct in stimulating the concept of adoption as one of the best ways to care for children deprived of their own parents—historically, a relatively new concept. For centuries adoption has been primarily a legal way of establishing status. In some countries in Europe, in Latin America and in the Far East where traditions are deeply rooted, the child-welfare concept of adoption is still a recent one, and in some adoption by relatives is about the only customary type. The fact that children in these countries are going abroad for adoption is making those concerned with child welfare look at their own laws and practices to allow more children to be adopted within their native country. Similarly, in the United States, agencies begin to wonder whether everything possible has been done to give the children living in institutions a chance of family life through adoption.

Although there is a general awakening of interest in new legislation and services centered around the child's own needs—specialized child-placing agencies do not exist everywhere in the world, and where they exist their methods may differ from ours. Nevertheless children will continue to come from all over the world, and likewise American children will continue to move to other countries, and there will be a continued need for the kind of preventive service that social agencies can offer in advance of their arrival and after it. It is certainly not a new fact that such preventive service saves the community as a whole unnecessary and much greater expenditures.

Many children were left homeless or fatherless by the recent war in Korea, just as by all other wars. What's to become of them?

Whether temporary legislation, such as the Refugee Relief Act, calls for agencies to put into effect a governmental program, or whether it is an individual request for service, a more effective way has not yet been found to protect children and families than through voluntary intercountry cooperation of social agencies willing to give their skill and time. It may be, as many of us hope, that governmental controls will be established in each country around the emigration and immigration of children so that they should not be allowed to leave their homeland or to enter any country unless it is in their best interests. Yet what is the best interest of a particular child can hardly be established by law. The skill and the objectivity of a social agency will be needed to give practical meaning to the spirit of the law.

[3] Bowlby, John, M. D.: Maternal care and mental health. World Health Organization. Geneva. 1951.

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COMBINING FORCES FOR MIGRANT CHILDREN

KATHRYN CLOSE

A STRONG CALL for cooperative effort among public and voluntary agencies within the States, among the States, and within the Federal Government to bring opportunities for a better life to the children of migrant farm laborers rang out in Washington in mid-May. This came from the combined voice of the 92 representatives of Federal, State, and voluntary agencies who attended a Conference on East Coast Migrants, May 17–19 in the Department of Health, Education, and Welfare.

Sponsored by the Public Health Service, the Office of Education, the Bureau of Public Assistance, and the Children's Bureau, with some financial assistance from the Field Foundation, the conference brought together health, education, welfare, and, in some instances, employment-service officials, from the 10 States involved in the East Coast crop-following migrant stream, as well as representatives from the church groups and other voluntary agencies which have demonstrated their concern for the well-being of the human units of which that stream is composed. The 10 States represented were New York, New Jersey, Pennsylvania, Delaware, Maryland, Virginia, North Carolina, South Carolina, Georgia, and Florida.

The delegates had been asked to work out some specific plans for themselves to set in motion a current of effort in behalf of the migrant families and their children. In answer they affirmed an intention to provide better services to these children by combining forces to see where the gaps lay and to fill them in, where possible. They concentrated, as charged, on State and community services to children, but not without some side glances at the effects of agricultural economics on the conditions in which these children live, and on State and local ability to finance improvements.

The sponsoring committee had selected the East Coast migrant stream as the focus of the conference with the hope that its size and comparative regularity of route would make it amenable to the kind of concentrated effort that could produce patterns for other areas. The committee had had its hopes stimulated by the lively interest and activity in behalf of these children already evident in some States.

The Problem

While the East Coast migrant stream is a brooklet compared with the great flow of mobile harvesters in the West, it is large enough to be of considerable importance in the production of the Nation's food supply. Everybody at the conference agreed that the number of families and children who travel from Florida to upper New York State and back from year to year, picking strawberries, beans, tomatoes, apples, or whatever is ready for harvest along the way, runs into many thousands, but they also agreed that the "free wheeling" progress of many of them makes exact figures unattainable. While employment-service registrations, according to Department of Labor statistics, show some 31,000 farm workers plus 3,000 children under 13 as moving north from Florida this year, a Labor Department spokesman pointed out that these figures not only do not show the total number of children among them, but do not include any of the families who, like John Steinbeck's famous Joads, move from crop to crop on their own.

Since the delegates had been invited to the conference to produce specific proposals for action, the structure had been designed to be conducive to this end. Opening with an informal coffee hour, the first day was largely taken up with two stage-setting general sessions where the Secretary of Health, Edu-

cation, and Welfare, Oveta Culp Hobby, described the purpose of the conference, one panel of discussants stated the problems as seen by people already working with migrants, and another briefly outlined the Federal consultative services and grant-in-aid programs which might be drawn into the picture. The large portion of the 3 days, however, was devoted to various group meetings, some of them organized along State lines and others according to fields of interest, where discussion was entirely free. Such a cross-fertilization of thought and experience produced a rich crop of ideas, which resulted not only in the requested recommendations, but in a number of individual State plans for action "when we get back home."

The goal of the first group of State meetings was to draw up lists of questions for consideration of the "small interest groups"—four each in the fields of health, education, and welfare—which met together the following day. These State meetings brought forth more than a hundred questions which, after the related and repetitious were combined by a committee, were allocated to the appropriate interest groups as groundwork for their construction of preliminary recommendations. These in turn were handed on to "large interest groups," composed of all the delegates in each specific field, where the proposals to be submitted to the conference as a whole at a final general session eventually took shape.

In her opening address Secretary Hobby had described the migrants as persons who "follow the sun for a living, but live in the twilight zone of citizenship." Descriptions of specific shadows in this twilight zone emerged throughout the conference. Longest, it appeared, is cast by their "Statelessness," for the discussions early revealed that while the 10 States represented considered these harvesters as economically necessary, none regarded them as "their own." In fact, some of the Florida representatives received a shock on discovering that while they tended to look on these peripatetic crop-pickers, who come around for about 7 months of the year, as just another group of their State's annual influx of northerners, the 9 States to the north saw them as Floridians. New York backed up the latter view by producing figures from a study which showed 42 percent of the people in the migrant farm families stopping in that State one summer were born in Florida. The ensuing discussions bore vivid testimony to the fact that having no State willing to be called "home" can mean more than just losing a vote to persons on the borderline of indigency. For them when trouble comes in the form of sickness or other distress the normal channels to aid are apt to be closed.

The Twilight Zone

Other characteristics of the twilight zone in which migrant children live emerged as poor housing and sanitation, inadequate home care, irregular schooling, no recreation or opportunities for normal friendships, inadequate or no medical attention and, for some, long hours of work. The difficulties in clearing away these shadows also emerged—State residence laws, community indifference or hostility, the here-today-and-gone-tomorrow aspect of migrancy

Greene's Studio, Homer, N. Y.

Children of migrant farm families in Smyrna and Pondville, N. Y., rest and play in day-care centers provided by the Division of Home Missions of the National Council of Churches of Christ in the U. S. A. which works in a number of States to improve conditions among migrant families. Child care was one of the urgent needs pointed out by the conference on migrants.

Stan Wayman from Montmeyer.

Ingenuity went into the creating of this Home Missions outdoor day-care center for migrant children in Florida. Such opportunities are rare among migrant children along the East Coast.

which blocks continuity of service, the impossibility of keeping track of "free wheelers," low public financial resources, and confusion over where the responsibility for improving conditions lies.

By request of the planning committee the conference's emphasis was on children with the focus on services. However, as the deliberations proceeded, it became increasingly evident that what happens to children cannot be entirely separated from economic problems. This showed up, for instance, in two unanswered questions involving child labor: As long as the average migrant farm worker earns less than $900 a year, isn't it natural from the family's point of view to set all hands to picking? Since a crop of beans, or anything else, usually ripens all at once and must be picked before it spoils, can even the most enlightened grower be expected to pay much attention to child-labor laws when adult pickers are in short supply? Even a well-organized employment service, it was pointed out, cannot guarantee that enough labor will be on hand when needed, as the exact time of ripening is unpredictable and usually the same for all farmers in an area.

Actually many States sent delegates from their labor and agricultural departments, as did the Federal Government. A few growers came, too, as part of their States' delegations. Their presence brought to light the overlapping interests of persons whose chief responsibility is to get the crops in and those whose main focus is on the health, welfare, and educational opportunities of the human beings involved; for it revealed a strong realization among the crop-conscious that the best pickers are those who are afforded good living conditions and whose children are well supervised. Thus the delegates heard of growers who provide well-built sanitary camps, supervised child-care facilities, and, occasionally medical care for their migrant farm families; and of responsible crew leaders who take a paternalistic interest in the families they lead from crop to crop. They also heard of the employment-service practice in some States of rating crew leaders according to their degree of responsibility.

However, a number of representatives from church groups which have been working among migrants challenged the expressed assumption that irresponsible crew leaders soon go out of business because the growers, or the migrants, will not take them back. They bore witness to deplorable conditions among the nonregistered crews—unsanitary, overcrowded camps, and small children left alone in automobiles all day or wandering unsupervised around dangerous drainage ditches. A young priest told of free-wheeling crew leaders who take truckloads of unsupervised boys under 16 from State to State.

The overwhelming majority of conferees seemed to be in accord with the principle, held out by Secretary Hobby in her opening address, that "those who, in communities and in States, are closest to people are the ones best able to direct the health, education, and welfare programs for them." However, this left the delegates grappling with some questions: How can you get communities to want to accept responsibility for migrants? What kinds of service do the *migrants* want? What about those rural areas where hardly any services exist for anybody? If a community does expand its services to meet the migrants' needs what happens to the extra personnel and equipment during the great portion of the year when the migrants are not there? Who will put up the money?

The conference arrived at no panacea, but produced enough suggestions to indicate that the answers to these questions must come from many sources—the migrants themselves, the growers, county commissioners, State legislators, Congress—and that the road to achievement lay through community education.

The conference had been asked to concentrate on how States and communities could extend their services to the migrant children and to pinpoint the ways in which the Federal Government could help them achieve this goal. For the most part they kept within this franchise. However, a few delegates

maintained that the migrants who "after all harvest the crops for the people of this country" need some special programs because they have special problems: their camp-life type of existence makes it impossible for them to care for a sick child at home; their occupation makes them ineligible for unemployment compensation and their homelessness for hospital or medical-care insurance; their constant mobility makes it impossible for them to receive continuity in their schooling or in health services. Doesn't this mean, an occasional voice asked, that some Federal programs might be indicated—mobile clinics or schools or a special medical-care plan as once provided by the now defunct Farm Security Administration?

Interstate Perspective

In spite of these questions the only special-service programs advocated in the recommendations, with the exception of an exploratory health examination project (to be mentioned later) were day-care centers and summer schools which could be operated from within the States. When their recommendations called for "Federal leadership" and "Federal funds" delegates asked for these to help in the extension of community and State services through established channels.

Nevertheless, the delegates clearly expressed the conviction that a migrant stream, like a river watershed, presents problems that are interstate in character, that if the children who are part of this stream are to receive continuity in schooling and services there must be interstate cooperation not only in exchanging information but in working out official policies and practices. Hence, they came forth with recommendations for a Federal interdepartmental committee on migrants to provide information and leadership to the States, for an interstate committee, and for uniform State action to waive or liberalize residence requirements for health and welfare services as far as migrants are concerned.

This interstate perspective also produced some recommendations for concrete projects and enough enthusiasm to promise quick transformance into reality. Chief among these are: (1) plans for the development of health and school records that might be carried by or sent on ahead of the migrant families to teachers and health officers; (2) an "exploratory project," to be financed by "outside sources," to provide health examinations for migrants at the point of departure for their annual crop-following tour. This last resulted from considerable discussion of the possibility of screening migrants for communicable disease, in which the constitutionality of any required procedure was seriously questioned.

In regard to the availability of services the conferees were as one in agreeing that the problem goes farther than the migrants, that in many rural areas of these East Coast States few, if any, health and welfare services exist. They testified to the fact that some counties have no full-time health departments, no child-welfare services, inadequate or no clinical or hospital facilities, no financial aid for needy persons other than those who fit into the Federally-aided public-assistance categories.

Remarking that "you can't help migrants without providing for the rest of the community," the health and welfare delegates turned some attention to seeking ways for community services to be extended. The health delegates recommended that supplementary Federal funds be made available for existing programs on a continuing basis. Similarly, the welfare delegates asked for Federal grants to States for general assistance to "any needy person without regard to residence." For other needs they looked to the States. Holding that day-care programs represent one of the most important means of protecting migrant children, they recommended that State agencies take the responsibilities for stimulating such programs and for providing them when no other groups are doing so. For these purposes they suggested that additional Federal funds be channeled through the child-welfare program. They also rec-

In this well-kept camp for migrant families a Home Missions program has encouraged the inhabitants to participate in camp management. The big tree substituting for the country-store "cracker barrel" is a popular center for impromptu meetings.

ommended reliance on local groups wherever possible and suggested that the States might stimulate these where they are not self-generating.

How to help the migrants take responsibilities themselves for improving their children's opportunities, also received considerable attention, for some evidence was produced, particularly in the health and educational fields, that migrant families do not always take advantage of what services are available. The phrase "adult education" resounded from the first day on and turned up in the recommendations of all three groups.

Adult Education

School attendance, the educators maintained, could only be improved as the migrants and crew leaders saw the importance of getting the children back to their home base in time for school opening or at least of entering them in schools in the communities where they happened to be. This last practice the educators recognized as posing some problems of teaching content, for how can a child stay interested if he finds the rest of the class beginning a book he has already finished or, as is more apt to be true, doing lessons based on knowledge that has passed him by? Moreover, some asked, how can a child learn from material based on experiences entirely divorced from his own, for instance from the usual story of "Daddy going to work in the morning while Mother takes care of the house"? Points of view differed, however, on the types of material that might help teachers attend the requirements of migrant children without setting them apart.

The educators did not limit their vision of adult education to the promotion of school attendance, but also recommended that materials be prepared to help migrants, crew leaders, and employment services know what community resources are available to them. Similar recommendations were submitted by the welfare and health groups. The education and welfare groups also recommended efforts to educate communities, and especially growers, to their responsibilities to migrants and to include migrants in the planning for their affairs. Migrant participation, the educators suggested, might be achieved through the promotion of indigenous leadership and the creation of camp councils in the labor camps.

How much change the conference will effect in the lives of migrants remains for the future to decide. A salutary omen, however, might be taken from the enthusiasm expressed by many of the delegates for this chance of getting together and by their stated intention of getting State committees organized when they returned home. While four States—New York, New Jersey, Pennsylvania, and Florida—already had such committees or commissions under way, in some others representatives from the various public and private agencies concerned with the migrants' problems had never met together until a few weeks before the conference when they assembled to prepare material requested by the conference planning committee. Still others had never met at all until they arrived in Washington. Now that the channels of communication were opened they promised to keep them open.

If first introductions were in evidence among State compatriots they were also common among comparable officials from different States. Evidence that these new lines to ideas and information would also be kept clear showed up in the reiterated insistence on the establishment not only of an interstate committee on migrants but also on subcommittees in particular subject fields. The educators, in fact, did not wait for such committees to be established before getting down to work together. Before the conference had adjourned they had already designed the much-talked-of traveling school record and had exacted promises from two States to try it out on an experimental basis.

So much examination and development of ideas and suggestions had taken place in the forging of proposed recommendations in the State and subject meetings that by the time these were presented to the conference as a whole at the final general session they were accepted with little further discussion. At this session the presiding officer, Earl Koos of the School of Social Work, Florida State University, listed seven products that had come out of the conference: (1) a consciousness of the problems which the migrant faces; (2) a new consciousness within the States of interagency responsibility for meeting these problems; (3) a concern for integration of effort, on all levels; (4) a new consciousness of the need for interstate cooperation; (5) new suggestions of ways in which Federal agencies can serve the States; (6) recognition that migrant children cannot be considered apart from their families; (7) a realization of the need for increasing perceptions—"the migrants' as well as our own."

Said Mr. Koos: "Since there is no such thing in our democracy as second-class citizenship—we must plan our services to give the migrants the same opportunities as others."

This certainly was the sense of the meeting.

PARENTS AND WAR-BORN CHILDREN

DALE B. HARRIS, Ph. D.

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FROM THE CHILD PSYCHOLOGY laboratory of Stanford University comes a significant contribution to research methodology and to our understanding of the significance of family for young children, "Father Relations of War-Born Children," by Lois Meek Stolz and associates.[1] This study used the dislocations of the war years in an ingenious combination of *post hoc* and experimental research designs. The central variable was presence or absence of the father during the first year of life of his first-born child.

In the experimental sample of 19 families, the G. I. fathers had been absent from their families during the war, but during the period of the study were living with them again. Another group of 51 families served as controls, and were similar in age, education, socioeconomic background, number in family group, and sex and age of children. In these the father, though a G. I., had not been separated from his family during the infancy of his child. Many families in both groups had second children at the time of the study.

On the basis of extensive interviews, the character of the father's early married experience and adjustment was reconstructed and his attitude toward his first-born assessed. The results showed that two-thirds of the war-separated fathers were not ready to accept their children when they returned from war. Most of these fathers were critical and disapproving of the behavior and personality characteristics of their children. They were significantly more severe and restrictive, and disagreed strongly with their wives over child-rearing methods more often than fathers in the control group. These fathers' attitudes "improved" to a statistically significant degree towards second children. As reported by the fathers, the war-separated children exhibited somewhat poorer attitudes toward their fathers than did the children in the control group.

While fathers in both groups tended to attribute to children characteristics which they saw in themselves, the nonseparated fathers more often saw themselves as persons who direct positively—who teach, help, support, and praise. The separated fathers somewhat more frequently than the others saw themselves in a negative-passive role—as resenting, complaining, distrusting, and retreating.

The study indicates that the war-separated group showed significantly more intrapsychic conflicts than the nonseparated group. The stress of separation shows plainly in these men's recollections. The greater severity they exhibited toward their children may arise from this quite as much as from their insecurity over their responsibilities as fathers of (to them) unknown children.

Interviews with the mothers supplied data on child training, descriptions of child behavior and personality, and the mother's view of the father-child relationship. No significant differences appeared between war-separated mothers' and nonseparated mothers' reports of circumstances of and reactions to pregnancy and birth, and to the sex of either their first-born or later children. Nor did there appear to be significant differences in the general life experiences of these groups of babies in their first year.

War-separated first-born children, compared with controls, did show more problems associated with eating, elimination, and sleeping; more evidence of fear and tension; and more dependency than both the children of the control group and their own younger siblings. But nonseparated first-borns also had more of such problems than the younger children in their families.

Is this evidence of the often suspected fact that

parental anxieties concerning their first-born arising out of inexperience, produce somewhat poorer behavior in the children? And that later children profit from earlier parental mistakes? If so, the war-separated infants seem to be somewhat worse off than the nonseparated.

In social relations, the war-separated first-born had poorer relations with playmates than the nonseparated first-born. In virtually every comparison they received less desirable ratings on the average than did the nonseparated, though the difference frequently fell short of statistical significance.

The interviews indicated that both fathers and mothers perceive and correctly assess many of the father-child relationships, the mother frequently showing more insight than the father into the disciplinary factors involved.

Behavior Reports

The second phase of this project used detailed observational records of the children in preschool and reports of behavior in controlled experimental situations, involving aggressive play with balloons, doll play, and "blocking" games. A story-completion test involving six father-child situations, and dramatic play with dolls completed the projective series.

While many of the specific comparisons proved nonsignificant, there were a number of interesting exceptions. War-separated children more often initiated social behavior than the other children but it was more likely to be "onlooker" or parallel in character. The groups were very similar in dominance-submission relations and initiated aggression about equally when combined with friendliness estimates, but the war-separated group scored more units of aggression with unfriendly connotations. The war-separated children were significantly more nonresistant to aggression than the controls. Few differences appeared in friendliness and sympathy categories. The war-separated initiated more dependent and less negative behavior toward adults. The nonseparated children more often responded to adult-initiated contacts with indifference, and the war-separated children to adult authority with disobedience or defiance.

These findings fall into place in the picture of the fathers. War-separated fathers were more severe and more irritable than the control fathers, and their children learned to be more quiet and submissive to adults, except in authority situations.

The findings of the experimental projective situations are somewhat less clear. Most of the comparisons were nonsignificant, statistically. The war-separated children tended to show somewhat stronger aggressive feelings than the nonseparated. This was particularly true for the two groups of boys. There was no evidence that the war-separated children were more inhibiting of aggressive responses, though the authors insist their methods were too crude to evaluate this feature properly. There were no differences in the amount or kind of aggression directed toward fathers or mothers, either within the groups or between the groups. The findings with story completion and dramatic-play completions are essentially negative.

The study makes a number of noteworthy methodological contributions. The interview content and experimental situations are ingenious and quite complete, and assess a variety of personality dimensions. The overall design has the merit of simplicity. At no point do the statistical techniques overreach the data's degree of refinement. Techniques for handling the observational records of the child in the group are especially praiseworthy. The method is "wholistic" in that it preserves the meaningfulness of the child's behavior; yet is analytical in that it separates the stream of behavior into classifiable units.

Another contribution, calling for further development, is a device for classifying children, regardless of group, who respond in a manner congruent with the modal pattern of one group. Here is an approach to pattern analysis which may be quite fruitful in analyzing masses of "qualitative" data wherein a pattern is suspected to exist. It is a form of "sign" approach which may permit the clinician to manipulate his "trends" or "tendencies" in orderly fashion.

Among the possible weaknesses of this study, from a scientific viewpoint, is the tendency to affirm in selected case histories relationships not borne out in the quantitative data. This is the familiar problem of lawfulness in the individual case *vs.* lawfulness in the group. There is also the tendency to remark on the direction of trends, even where the statistical tests indicate that the trend may be due to sampling error. Some will consider the 5-percent criterion for significance too lenient for the small number of cases involved.

What does the study tell us? Clearly the impact of father-separation on the child is minimal. It is the *reunion* with the father which produces problems. This study brings out distinctly the developmental character of the parent-child relationship. For the

war-separated mothers, their infants constituted a happy, symbolic link with absent husbands. The mothers "grew" into and with the relationship.

Not so with the fathers. They returned to an experience which had gone ahead without them. This added to their sense of lack of control over events. The study shows that the war-separated fathers exhibited many more signs of intrapsychic conflict and of postwar adjustment difficulties than the nonseparated men. Thus, they brought more stress of their own into their children's development. However, these fathers "grew" into a more adequate relationship with their next children.

Thus the importance of the "climate" established in a continuing relationship is demonstrated. Not only is the intrapsychic life responsive to intrafamilial relations, but also the relationships within the family itself have a developmental, dynamic character. As the study shows, this process has a measurable impact on the personality development of children. Undoubtedly it also has such an impact on the adults concerned.

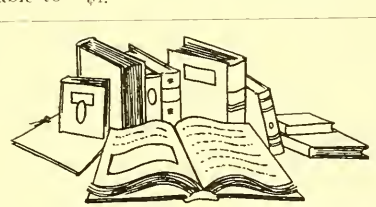
The study also reveals a picture of the over-cared-for first child. About as many differences appear between first and second children as between children of separated and nonseparated families. Superimposed on the effects of his mother's first-child anxiety is the war-separated child's experience with his father's separation-induced anxiety. Nevertheless, one must admit that the differences attributable to separation are actually few in number considering the many comparisons made, small in extent considering the total variation of behavior exhibited within each group.

Here again is evidence of the fundamental resilience of childhood. One suspects that, unless there is continued selective interaction between children and environment reinforcing the small differences revealed by this study, these differences will fade as development, under changed circumstances, continues. As the authors note, the very process of study was educative to the parent-participants who achieved reorientation by focusing their attention on their problems. This, too, is a valuable, practical outcome of the project.

While it demonstrates the child's sensitivity to pervasive as well as traumatic experience, this study testifies to the basic significance of a reasonably good emotional climate. As far as personality at age 4 or 5 is concerned, the inference could be drawn that the second and third years are possibly more significant than the first. It is hoped that other studies, equally good methodologically, will be forthcoming to throw light on these important, but heretofore not too well handled, problems.

[1] Stolz, Lois Meek; and Dowley, Edith; Chance, Erika; Stevenson, Nancy; Faust, Margaret; Johnson, Laverne; Faust, W. L.; Engvall, Alberta; Ullman, L.; Ryder, Joyce; Garvin, D. B.: Father relations of war-born children. Stanford, Calif.: Stanford University Press, 1954. pp. viii+365. $4.

Book Notes



GROUP WORK IN THE INSTITUTION; a modern challenge. Gisela Konopka. Whiteside, Inc., and William Morrow & Co. New York. 1954. 304 pp. $4.50.

This book analyzes the application of social group work in residential institutions for dependent, physically handicapped, and delinquent children; for unmarried mothers; for the aged; and for adult offenders.

The author identifies the roles of the social group worker in institutional life, as well as some of the problems involved in integrating the group worker's efforts with those of the institution staff as a whole.

AMERICAN SOCIAL WORK THEORY; a critique and a proposal. Arthur P. Miles. Harper & Bros. New York. 1954. 246 pp. $3.

In order to formulate an adequate theory of American social work, the author, who is Director of the School of Social Work, University of Wisconsin, suggests that: "(1) An intensive and detailed analysis should be made of the actual practice of social work. . . . (2) After such an analysis, cooperative social-science research could aid in developing a more sophisticated base for the practice of casework, groupwork, and community organization. (3) Finally, the acceptance of a broad social-scientific point of view by social-work practitioners would give stability to such research."

GROUP WORK IN COMMUNITY LIFE. Edited by Clyde E. Murray, Marx G. Bowens, and Russell Hogrefe. Association Press. New York. 1954. 245 pp. $4.75.

As the authors describe the purpose of this book, it is "to examine a few significant projects which show the effectiveness of the group-work method in community settings." Projects in 7 urban communities and 2 rural areas are reported on, under such headings as "The Neighborhood Center for Block Organization," "Trailer Court and Town—a New Frontier for Service," and "An Agency Works with Street Gangs." Methods and staffing are discussed, as well as administrative planning and review.

TREATMENT OF THE DELINQUENT ADOLESCENT; group and individual therapy with parent and child. Harris B. Peck, M. D., and Virginia Bellsmith. Family Service Association of America, 192 Lexington Ave., New York 16, N. Y. 1954. 147 pp. $2.

Out of their experience in the Bureau of Mental Health Services of the New York City Court of Domestic Relations, the authors—a psychiatrist and a psychiatric social worker—offer some tentative solutions to problems of providing treatment services in a children's court setting for delinquent adolescents and their parents. The book "reflects some of the gains that have been made in the application of psychiatric, psychological, and casework principles to these difficult problems of behavior, by the courts and allied services and institutions." A fairly detailed presentation is given to treatment practices and processes that seem to the authors especially useful.

READINGS IN THE THEORY AND PRACTICE OF MEDICAL SOCIAL WORK. Edited by Dora Goldstine. University of Chicago Press. Chicago. 1954. 344 pp. $5.

The editor of this collection of 27 articles from professional periodicals says that in examining the literature of medical social work she found "a tremendous outpouring of 'interpretive' writing, but a paucity of writing that analyzes casework practice or program-development activities by which social work becomes integrated with medical care."

In selecting from the first group she tried to choose those that seemed to do the best job of illustrating the method and the content of such interprofessional communication. From the comparatively small number of articles available in the second group she aimed to choose those few "that analyzed the medical social function not only in casework services but in its administrative, community-planning, and educational aspects." She also included her own review and evaluation of medical social work over the past 45 years.

The book "focuses primarily on the use of medical social work in direct services to patients and their families, as this practice developed in hospitals and clinics."

TOWARDS AN UNDERSTANDING OF JUVENILE DELINQUENCY; a study of 8,464 cases of juvenile delinquency in Baltimore. Bernard Lander. No. 578 of the Studies in History, Economics, and Public Law, edited by the faculty of political science of Columbia University. Columbia University Press. New York. 1954. 143 pp. $3.

This statistical study analyzes the relation between the socioeconomic data for census tracts in Baltimore and the juvenile-delinquency rates for the period 1939–42.

In seeking to explain the differences between certain areas in delinquency rates, the author points to community instability as the most important factor. "The delinquency rate in a *stable* community," he says, "will be low in spite of its being characterized by bad housing, poverty, and propinquity to the city center. . . . In a stable community a child is born and raised in a context of established norms, which are supported by a social consensus . . . Generally the child acts to satisfy his needs in a manner which has the approval of society. If he acts in a deviant fashion, formal and informal controls including his own ego . . . act to deter the child from further deviant conduct."

THE UNMARRIED MOTHER IN OUR SOCIETY; a frank and constructive approach to an age-old problem. Sara B. Edlin. Farrar, Straus, and Young. New York. 1954. 189 pp. $3.

Mrs. Edlin contrasts presents conditions in an institution for unmarried mothers with those of 1912, when "the New York Foundling Asylum maintained a 'receiving basket' at its entrance door, so that a mother could by the mere act of depositing her baby in the basket rid herself of the 'badge of shame.'"

While noting no universal sequence of cause and effect can be valid for all unmarried mothers, the author maintains that the predominant factor is the existence of an unwholesome relationship between the girl and her parents.

HOW TO HELP THE SHUT-IN CHILD; 313 hints for homebound children. Margery D. McMullin. E. P. Dutton & Co., Inc. New York. 1954. 192 pp. $2.75.

For a number of years the author has been the guiding force of the Handicapped Children's Home Service, a voluntary organization that brings recreation and companionship to many New York City children referred to it by hospitals.

Among the ideas the book offers are some that the Service has found successful, as well as some that have been tested by parents, including the author herself, whose boy was bedfast for 2 years. The book offers practical suggestions for entertaining and encouraging boys and girls who are cut off from contacts outside the home. They are planned especially "for uniting the handicapped child with his up-and-around family."

ROOFS FOR THE FAMILY; building a center for the care of children. Eva Burmeister. Columbia University Press. New York. 1954. 203 pp. $3.25.

Four years after Lakeside Children's Center, in Milwaukee, moved out of its 63-year-old congregate building into four cottages especially planned as a modern children's institution, the Center's director wrote this account of the change-over from the old home to the new. While presenting enough detail to help other institutions change from congregate to cottage living, the author does not let the physical aspects of the home overbalance the human side. She says, for example, "The tone of the institution is set by the staff who work within it, rather than by the details of its construction."

Many readers will remember Mrs. Burmeister's warm, informal account of life at Lakeside Children's Center, titled "Forty-five in the Family; the story of a home for children."

PROJECTS AND PROGRESS

WHC Followup

If the needs of the expanding number of children and youth in this country are to be met, agencies, and individuals too, will have to use more effective ways of working together, said Mrs. Margaret Price, Chairman of the National Advisory Council on Children and Youth, at the Conference on Children and Youth, held in Washington, May 5–6.

This conference, the first joint meeting of the National Advisory Council and the Interdepartmental Committee on Children and Youth brought together representatives of Federal agencies and of State groups representing both public and voluntary work for children, to consider how programs might be developed or adapted to meet needs arising from current economic and social changes.

The Advisory Council represents 53 State and Territorial committees and commissions, some appointed by the Governor of the State, others by their State legislature. Established in 1949 in preparation for the Midcentury White House Conference, it has worked since the 1950 sessions to advance the Conference findings. The Interdepartmental Committee, organized in 1948, coordinates the programs affecting children and youth of nine Federal agencies, including 29 bureaus and offices.

These two groups joined hands last October to help the State committees and the Federal agencies to keep in touch with one another's programs and to move more effectively toward mutual goals. The May 5–6 conference grew out of this working relationship. Eighty-seven persons attended the joint meeting: 44 of these—from 25 States—representing the Advisory Council and 43 representing Federal agencies.

The chairman of the Interdepartmental Committee, Oveta Culp Hobby, Secretary of Health, Education, and Welfare, reminded the participants that although the Federal Government is concerned with the well-being of children and youth, the major responsibility for this rests with the States and with local communities.

Two panel discussions were held, one presenting the needs as seen in individual States; the other, from the point of view of Federal agencies. The latter discussed some of the implications of the rapid increase in child population, and exhibited a chart showing that in 1940 there were 40 million children under 18 years; 54 million in 1953; and that probably there will be 63 million in 1965. Obviously, the panel agreed, it becomes more and more difficult for the States to offer adequate services for children.

The increasing child population formed a backdrop for discussions by six work groups, each of which concerned itself with specific ways of adapting current programs to changing conditions. Their subjects were: Home and Family Life; Mental Health; Employment and Transition From School to Work; Agricultural Migrants; Juvenile Delinquency; Education for Citizenship Responsibility.

The work group on *home and family life* noted that contemporary society is going through greater changes than have occurred in the last two thousand years. In view of this fact, the family assumes greater importance than ever before as a basis for an orderly society, the group agreed, and found it fitting that the community as a whole appreciate better the contribution of parenthood to society. The group urged more family-centered programs and activities and stressed the importance of agreement in the community on the primary values to be sought in family life.

The *mental-health* group emphasized four points:

1. Preventive services should be stressed, particularly at the very early stages, such as the prenatal, infant, and preschool. The word "preventive," however, seemed to the group too negative. They preferred a positive approach, or guide, so that a child may be directed to a full, happy, normal life in a happy home.

2. A greater effort should be made to coordinate the work of all community facilities working with parents, babies, and preschool children.

3. Through group discussions, in which individuals join in planning toward solving their problems, it will be possible to spread services to more people.

4. Agencies offering specialized services should recognize the dependence of their services upon basic generalized personnel, such as public-health nurses, social workers, and nursery teachers.

The work group on *employment and transition from school to work* noted the increased number of adolescents in the population and the tendency for them to experience a longer transition between school and employment. The group sought ways of giving high-school students more help in learning to adapt themselves to employment, through summer and after-school jobs and of helping those school leavers to find full-time work.

The group agreed that if young people of high-school age are to attain a rounded development, they need not only schooling and social activities but also experiences in earning money. Positive programs for finding good employment opportunities for youth can offset pressures toward socially unacceptable activities, the group said.

The work group on *agricultural migrants* examined three aspects of their subject: Exclusion of migrants from regular community services, exclusion of migrants from benefits provided other citizens under labor and other laws; community attitudes toward the migrants.

It made the following recommendations:

1. That the Interdepartmental Committee establish a Federal clearinghouse of information on migrants, and that State and local committees be encouraged to carry out similar programs.

2. That State committees encourage formation of specialized committees, or some other mechanism for focusing and coordinating the effort of State public and voluntary groups in behalf of migrants.

3. That local groups and agencies cooperate in efforts to discourage employment of illegal entrants to the United States.

The work group on *juvenile delinquency* prefaced its report by stating that the Ten Commandments should be made an integral part of the daily lives of parents and their children.

Among other recommendations the

group asked that State committees support in each State establishment of an official agency to lead in developing standards for services for delinquents; and that the committees encourage agency consultation to police and give attention to the importance of juvenile police units. The group also suggested that juvenile courts be encouraged to join the uniform statistical reporting system of the Children's Bureau.

Concerned with the problem of runaway children, this group urged the Children's Bureau to develop and further an interstate compact for their proper handling and placement.

It urged "national action" in the efforts to combat juvenile delinquency, with the following statement:

"The group is convinced of the need for national action in the field of juvenile delinquency in respect to technical aid in prevention and treatment, public information regarding the causes, fact finding and research, and training of personnel. It believes that a single agency of the Federal Government should undertake these activities or extend present functions to include them. Basic financing of these activities should come from Federal funds, though the agency should be authorized to accept private funds . . ."

The work group on *education for citizenship responsibility* not only emphasized the formal techniques of education for citizenship responsibility, but agreed that broad citizen experience in community affairs is one of the most effective means of educating for responsible citizenship.

Urging that communities make use of the abilities, energies, and skills of youth, the group concluded:

"With the rapid technological changes that are taking place in our world, have come equally striking changes in methods of working with each other. It is imperative, then, that those of us who are working with children make use of this body of knowledge."

—Sarah L. Doran

For the Handicapped

Thirty-three specialists in the care of handicapped children, from more than a score of countries, are receiving advanced training at the International Children's Center, in Paris. The center is operated by the French Government with help from the United Nations Children's Fund and the World Health Organization.

Those attending the course include surgeons, nurses, physical therapists, teachers, and social workers, from 22 western countries.

Before these trainees came to the Center, many of them, although acknowledged experts in their own fields, had only a limited knowledge of the importance of teamwork—of coordinating physical care, education, and vocational guidance in helping the handicapped child live a more normal life. Six weeks of lectures by top international authorities, along with visits to specialized hospitals and centers in France and Belgium are provided to demonstrate the value of the team approach to rehabilitation.

Home Help

The London (England) County Council's Public Health Department has been authorized to test out a new wrinkle in the "home help" program in that country. Launched in December 1953, this is a "child help" scheme that enables children, temporarily deprived of the care of parents or guardians, to continue to live in their own homes and so to avoid having to be sent to a residential nursery or other establishment. It is anticipated that such an arrangement will not only lessen the children's sense of deprivation but also save public money.

The service is limited to cases where there is no parent or other adult available to sleep in the home at night, such as situations where the father works at night and the mother is in a hospital.

Duties of a "child help" include meeting younger children after school (or collecting "under-fives" from a day nursery); preparing their tea; assisting in their evening activities; seeing them to bed; sleeping in the home; fixing breakfast and getting the children off to school again. "Child helps" also attend to incidental domestic tasks and shopping. During school holidays, they undertake full care of children of school age as substitutes for mothers, in addition to providing for any preschool children. Parents are expected to provide enough money for the maintenance of their household. The "child help" contributes the cost of her own keep, and disburses household expenditures as if she were at her own home. After one year's experiment, the County Council will decide on whether this scheme is to be put on a permanent basis.

Parent Education

As a step toward finding out what additional training public-health nurses need in order to work effectively as leaders of parent groups, the Child Study Association of America offered a leadership training program for nurses during the past spring, with the sponsorship of the Children's Bureau and the New York State Department of Health.

The 15 nurses who served as leaders-in-training for this demonstration were selected from health departments in counties in and around New York City. They met during a 3-month period, in which they took part in weekly observation of parent groups in theoretical sessions and in group seminars. They studied the techniques of parent-group education and basic concepts of child development, with special recognition of the parents' concerns at each stage of the child's growth.

In the fall of this year the nurses who took part in the program will lead parent groups in their own communities, supervised by staff of the Child Study Association.

To follow the step-by-step progress of the participants in this program, the association has set up an advisory committee on evaluation, with representatives from National, State, and local agencies.

Similar training programs for social workers and educators have been given by the association during the past 3 years.

Nutrition

The Food and Nutrition Board of the National Research Council has issued a 1953 revision of its "Recommended Dietary Allowances." (Pub. 301, National Academy of Sciences, National Research Council, Washington, D. C. 36 pp. 50 cents.)

Dietary recommendations, for calories and for a number of essential nutrients, were first adopted by the Board in 1941. They were revised in 1945 and in 1948 to reflect additional knowledge of nutritive requirements resulting from research. The new edition makes minor changes in allowances for pregnant and lactating women, for infants, and for boys from 10 to 12.

All the allowances are designed for

maintenance of good nutrition in healthy persons in the United States, when the national food supply is abundant.

The Mentally Retarded

Baltimore's citizens are supporting a Foundation for Mentally Retarded and Handicapped Children.

Begun by the Civitan Club, the work is now supported by admission charges to an annual city-wide music festival, other fund-raising projects and contributions from individuals.

The Foundation is financing medical research on mental retardation—its treatment and prevention—through a grant to the Johns Hopkins University. It is also paying for scholarships for 82 Maryland teachers specializing in teaching the mentally retarded, and for educational research in schools for such children.

• • •

A center for work with retarded children is being planned by the Nassau County (N.Y.) chapter of the Association for Help of Retarded Children. At this center, which will be located at Nassau Hospital in Mineola, a team of specialists will plan an individual program for each child, based on careful study and testing. The programs will include medical and other treatment, at institutions and elsewhere, and vocational and educational training as required.

Home and Foster Care

A pilot project to demonstrate the use of casework services to keep children in their own homes is being established in New York City through the use of Federal funds for child-welfare services, made available through the Children's Bureau. The program calls for three units in selected welfare centers of the City Department of Welfare to provide services to families and children who are threatened with family breakdown.

At present about 20,000 children in New York City are being cared for outside their own homes, most of them in institutions, and some in temporary shelters awaiting permanent placement. About 8,000 are in foster-family homes, the majority placed by private child-caring agencies with the aid of city funds.

Five years ago the backlog of children awaiting placement became so serious that the city established a division of foster-home care within the Department of Welfare to help relieve the situation. Since then the division has placed nearly 500 children, but the availability of foster-family homes for children, especially Negroes, Puerto Ricans, and the very young, is still far under need.

The new program by which it is hoped to show a way of preventing the need for many placements, will serve families not included in the Department's present Youth Board sponsored program of casework services to families in high delinquency areas.

Against Disease

A 5-year pilot study to determine the best way to curb rheumatic fever has been initiated by Irvington House, Irvington, New York, a hospital for children with rheumatic heart disease. The work will be conducted at a prophylaxis clinic at the Institute of Physical Medicine and Rehabilitation of the New York University-Bellevue Medical Center, with which Irvington House is medically affiliated.

Grants to help carry out the study have been awarded by the Public Health Service of the Department of Health, Education, and Welfare; the American Heart Association; the New York Heart Association; and the Westchester Heart Association.

• • •

Yaws, a tropical disease that until 1950 affected approximately one-third of the rural population of Haiti, reaching 50 percent of the inhabitants in some areas, has been almost wiped out by the Haitian Government, in cooperation with the World Health Organization and the United Nations Children's Fund (UNICEF), according to a recent report from the Pan-American Sanitary Bureau, WHO's regional office for the Western hemisphere.

Juvenile Delinquency

Juvenile delinquency rose again in 1953 for the fifth consecutive year, according to reports received by the Children's Bureau from juvenile courts throughout the country.

The figures indicate that the reporting courts handled 13 percent more such cases in 1953 than in 1952.

A preliminary estimate based on these reports puts the number of children brought into court because of delinquency at 435,000, a new all-time high. The previous high of approximately 400,000 cases was reached in 1942 and in 1945.

Final figures are expected to show a 45- to 50-percent increase in delinquency cases in the 5 years since 1948, as compared to a 7-percent rise during the same period in the child population 10 to 17 years old, the age group of the majority of delinquent children handled by the juvenile courts.

Police-arrest data reported by the Federal Bureau of Investigation also indicate a rise in juvenile delinquency, the number of "arrests" of persons under 18 increasing 8 percent in 1953 over 1952. According to the 1953 figures, juveniles under 18 committed 54 percent of auto thefts, 49 percent of burglaries, 16 percent of rapes, 5 percent of assaults, and 4 percent of homicides.

Here and There

Kansas and New Hampshire will soon have State-operated residential treatment centers for disturbed children, according to plans now underway. These will be located at the Topeka State Hospital and the Concord State Hospital . . . In Massachusetts, the Metropolitan State Hospital, at Boston, which has had a residential treatment program for psychotic children since 1945, is opening a new children's unit, to include both outpatient and inpatient divisions. Of the 2,000 child admissions to the hospital since the inauguration of the program, 1 in every 15 has been a readmission, 1 in every 50 a third-time admission, 1 in every hundred has appeared four times or more.

A total of 645 runaway children under 16 years of age from other States and 143 from within the State were picked up in Pennsylvania in 1952, according to an estimate arrived at in a study made by Pennsylvania Department of Welfare's Division of Rural Child Welfare. The report presents information on the handling of these children and questions the procedure of classifying all runaways as delinquents. . . . The New York City Youth Board has inaugurated a series of monographs dealing with the agency's experience during the 6 years of its efforts toward delinquency prevention and control.

Readers' Exchange

(Continued from page 124)

rightly points out that there must be interagency groups, local, State, and interstate (and I would add Federal), to map out a comprehensive and unified program.

Third, it highlights the worst sufferers from "this complexity of social and economic problems"—i. e., the children in the families who move from State to State in their attempt to make a livelihood.

It is gratifying that this same issue of CHILDREN announces that the Department of Health, Education, and Welfare is initiating a Pilot Project in an attempt to assist the States in providing the services that have so long been lacking for this segment of our population. But one thing is clear as day to students of the migrant problem: *such services require funds.* In dealing with a problem as essentially interstate in nature as is migrancy, it may well be that Federal leadership in bringing the States together to work out a program will prove to be ineffectual unless there is also made available to them Federal financial assistance to inaugurate the needed services.

Gertrude Folks Zimand,
General Secretary, National Child Labor Committee, New York

DYBWAD: Reassurance for leaders

Some of the things pointed out by Gunnar Dybwad's article ("Leadership in Parent Education," CHILDREN, vol. 1, no. 1, pp. 10–14) have long needed to be spelled out. The terms "catalyst" and "interpreter" seem to describe much more clearly than "leader" the role many of us see for ourselves in Family Life Education. The dynamic quality of such leadership is defined in his stated goal of helping parents to "understand their children's developmental needs, to recognize their own goals as parents and to work out their solutions from an awareness of existing differences as well as similarities in our society." The qualifications for leadership that he sets forth seem attainable in any setting with a planned program of parent education.

The Child Study Association's extensive experience in terms of time and numbers have made it possible for that organization to attain some of the clarity that can serve as a guideline to some of us Johnny-come-latelies in the parent-education field. I believe, however, that the 1952 Child Study Association's Conference theme of Parents in Search of Self-Confidence needs to be applied to leaders as well. Dr. Dybwad shows his awareness of the many demands on the leader for poise, sensitivity, and skill in human relationships. The burden this imposes, along with the lonely road traveled by many professional parent educators in "outpost" settings, calls for reassuring those of us who are struggling with ways of helping that are relatively new to us.

Grace C. Maybery, Supervisor Family and Children's Service, Minneapolis, Minn.

SOME INTERNATIONAL PUBLICATIONS

THE MENTALLY SUBNORMAL CHILD; report of a Joint Expert Committee convened by WHO with the participation of United Nations, ILO, and UNESCO. World Health Organization, Geneva, Switzerland. 1954. 46 pp. For sale by International Documents Service, Columbia University Press, New York. 25 cents.

This report urges governments to provide aid for children with physical or mental handicaps and to coordinate services so as to allow for the fullest possible development of these children. With regard to the mentally handicapped, it points out that "the prevalence of mental subnormality is such that in all countries its social costs are high," and that "there are therefore few societies which cannot afford to provide some services for their mentally subnormal." The report outlines the nature and functions of such services and offers guidance for their development.

EUROPEAN CONFERENCE ON HEALTH EDUCATION OF THE PUBLIC. Regional Office for Europe, World Health Organization, Palais des Nations, Geneva, Switzerland. 1953. Not for sale; but a limited number of copies available on request from the Regional Office for Europe, WHO, for distribution to libraries and health institutions.

This is a report of the first European Conference on Health Education of the Public, held in London April 10–18, 1953. The conference was sponsored by the World Health Organization, Regional Office for Europe, in collaboration with the Ministry of Health, London; the Department of Health for Scotland; and the Ministry of Health and Local Government for Northern Ireland. It was planned on the basis of visits to 13 countries by health-education consultants from the WHO Regional Office for Europe.

JOINT UN/WHO MEETING OF EXPERTS ON THE MENTAL-HEALTH ASPECTS OF ADOPTION. Final Report. Technical Report Series No. 70. World Health Organization, Geneva, Switzerland, 1953. 19 pp. For sale by International Documents Service, Columbia University, New York. 15 cents.

Principles of mental health that are fundamental to good adoption practice are discussed in this report in the hope that calling attention to these principles will lead to the improvement of current procedures.

SCHOOL FEEDING; its contribution to child nutrition. Marjorie L. Scott, Nutrition Officer, Nutrition Division, Foood and Agriculture Organization of the United Nations. Rome, Italy, November 1953. 129 pp. For sale by International Documents Service, Columbia University Press. $1.

Information about existing school-feeding programs in different countries has been obtained by FAO from governments and supplemented through direct study of such programs by FAO nutrition officers in the field.

The proceedings of the Madras, India, meeting of the International Conference of Social Work, highlighted by Donald S. Howard in the March-April issue of CHILDREN (vol. 1, no. 2, p. 77) can be purchased for $3 by members and $4 by nonmembers from the U. S. Committee of the Conference, 345 East 46th Street, New York 17, N. Y.

SOME U. S. GOVERNMENT PUBLICATIONS FOR PROFESSIONAL WORKERS

Publications for which prices are quoted are for sale by the Superintendent of Documents, United States Government Printing Office, Washington 25, D. C. Orders should be accompanied by cash, check, or money order.

THE CARE OF CHILDREN IN INSTITUTIONS; a reading guide. Martin Gula, Consultant on Group Care. U. S. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. 1954. 45 pp. Processed. Single copies available from the Children's Bureau without charge.

Nearly 200 references are given in this annotated guide to publications on care of children in institutions. Most of the references relate to programs for dependent children, but apply also to other institutional programs.

HOMEMAKER SERVICE IN THE UNITED STATES, 1954; a directory of agencies offering such service. Compiled by the Children's Bureau in cooperation with the National Committee on Homemaker Service. U. S. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. April 1954. 13 pp. Processed. Single copies available without charge from the Children's Bureau.

Ninety-seven social agencies in 38 States are listed in this 1954 directory of agencies employing homemakers. The directory was prepared by Maud Morlock of the Children's Bureau, assisted by Jean Kallenberg of the Family Service Association of America. This is a revision of an earlier edition.

POLICE SERVICES FOR JUVENILES; including the report of a conference held at East Lansing, Mich., on August 3–4, 1953, sponsored by the Children's Bureau in cooperation with the International Association of Chiefs of Police and the Special Juvenile Delinquency Project. U. S. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. CB Pub. No. 344. 1954. 91 pp. 35 cents.

This publication, like "Standards for Specialized Courts Dealing With Children," is one in a series of publications on juvenile delinquency made possible by collaboration between the Children's Bureau and the Special Juvenile Delinquency Project—a project privately supported by foundation funds, but sponsored by and working in close association with the Children's Bureau.

Included is a report on a discussion of various aspects of the subject of police services for juveniles, at a conference of about 50 leading police officials and representatives of related fields; and also material presented at that conference, incorporating the opinions of many persons who were consulted beforehand but who were not present.

An appendix, with 25 tables, provides a statistical review of police services for juveniles in the United States as of 1952, the reviews based on responses to a questionnaire distributed to members of the International Association of Chiefs of Police by that Association and the Special Juvenile Delinquency Project.

This bulletin is not intended to offer a finished picture of how the police can or should work with juveniles, but it is expected to serve as a rough guide for officials and citizen groups who seek ways to make the police role in regard to juveniles more positive and more effective.

STANDARDS FOR SPECIALIZED COURTS DEALING WITH CHILDREN. Prepared by the Children's Bureau, U. S. Department of Health, Education, and Welfare, in cooperation with the National Probation and Parole Association and the National Council of Juvenile Court Judges. CB Pub. 346. 99 pp. 35 cents.

This publication was discussed by two authorities in CHILDREN, vol. 1, no. 3, May–June 1954, pp. 102–106.

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A PROFESSIONAL JOURNAL ON SERVICES FOR CHILDREN AND ON CHILD LIFE

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HEALTH, EDUCATION, AND WELFARE
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SOCIAL SECURITY ADMINISTRATION
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CHILDREN'S BUREAU
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SEPTEMBER · OCTOBER 1954

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A Clinic for Adolescents

Preparation for Healthy Parenthood

Conference on Juvenile Delinquency

International Action for Children

VOLUME 1
NUMBER 5
SEPTEMBER–OCTOBER 1954

children

A professional journal on services for children and on child life (*formerly* THE CHILD)

For 20 years Dr. J. Roswell Gallagher has devoted attention to adolescents. He served successively as physician at the Hill School, Pottstown, Pa.; Phillips Academy, Andover, Mass.; and Wesleyan University, Middletown, Conn.; before joining the staff of the Children's Hospital in Boston and organizing the Unit he describes in these pages. Through research sponsored by the Carnegie Corporation and the Grant Foundation, Inc., he has contributed extensively to knowledge about the physiological, growth, medical, and emotional problems of adolescence.

A psychiatrist whose major concern is to find ways of applying knowledge about mental health to public-health work, Dr. Gerald Caplan has conducted experiments in this direction not only at the Harvard prenatal clinic he writes about here but also at a well-baby clinic in Israel, where for 4 years he was adviser in psychiatry to the Israeli Minister of Health. In his native England, he engaged in research in shock treatment and in psychiatric work with children at the Tavistock Clinic in London.

Before becoming director of the Special Juvenile Delinquency Project, Bertram M. Beck was for 4 years with the Community Service Society in New York, most recently as assistant director of its Bureau of Public Affairs. A graduate of the School of Social Service Administration, University of Chicago, he has had experience in family casework, child guidance, institutional administration and parole supervision. During World War II he served as psychiatric caseworker with the United States Air Force.

Problems of hazardous employment among children and youth have long concerned Clara M. Beyer, who writes in this issue of pinboys in bowling alleys. Before joining the staff of the Bureau of Labor Standards in 1934, she headed the Industrial Division of the Children's Bureau, then also in that Department. Previously she was executive of the Minimum Wage Board of the District of Columbia. A native Californian, she has taught at University of California and Bryn Mawr College.

The only woman with director's status presently in the United Nations Secretariat, Julia Henderson has been with the UN staff since the days of the Preparatory Commission. Originally on loan through the U. S. State Department she became chief of the policy division of the UN Bureau of Finance before going to her present position in 1950. With a Ph. D. from the University of Minnesota, she was the first woman ever admitted to Harvard University's Graduate School of Public Administration.

Frontispiece

"TODAY, education is perhaps the most important function of State and local governments. Compulsory school attendance laws and the great expenditures for education both demonstrate our recognition of the importance of education to our democratic society. It is required in the performance of our most basic public responsibilities, even service in the armed forces. It is the very foundation of good citizenship. Today it is a principal instrument in awakening the child to cultural values, in preparing him for later professional training, and in helping him to adjust normally to his environment. In these days, it is doubtful that any child may reasonably be expected to succeed in life if he is denied the opportunity of an education. Such an opportunity, where the State has undertaken to provide it, is a right which must be made available to all on equal terms.

We come then to the question presented: Does segregation of children in public schools solely on the basis of race, even though the physical facilities and other 'tangible' factors may be equal, deprive the children of the minority group of equal educational opportunities? We believe that it does . . .

". . . To separate them from others of similar age and qualifications solely because of their race generates a feeling of inferiority as to their status in the community that may affect their hearts and minds in a way unlikely ever to be undone . . .

"We conclude that in the field of public education the doctrine of 'separate but equal' has no place. Separate educational facilities are inherently unequal . . ."

Brown v. *Board of Education, Supreme Court of the United States. May 17, 1954.*

—Photo by Esther Bubley

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READERS' EXCHANGE

BECHTOL: Encouraging to Physicians

As Dr. Charles O. Bechtol points out, it is encouraging to physicians faced with the problem of prescribing prosthetic appliances for young children to know that the Advisory Committee on Artificial Arms of the National Research Council is to apply its knowledge to the problems of the child amputee. (See "Artificial Limbs for Child Amputees," CHILDREN, Vol. 1, No. 3).

The decision of the committee to use this knowledge for training physicians and therapists, rather than simply to release the device to the public, is highly important.

As Dr. Bechtol states, the greatest needs at the present time are for parental guidance, for more knowledge about the proper age at which to fit a child with an artificial arm, and for the type of arm best suited to do the tasks the child is interested in performing at various age levels. In our children's division, we have found that around 4 years of age seems to be the best time to supply the child with an artificial arm, because it is the age when he is most interested in bimanual activities such as stringing beads, scribbling on paper, and cutting with scissors.

Is the utility hook or the functional hand better for a child? Personally I will have to see more evidence on the advantage of hooks than is now available before I will prescribe one for a pretty little girl. At Children's Service we have found that usually the functional hand meets the needs of our child amputees and it seems to be more acceptable to parents. As the child develops and wishes to perform activities which are not possible with the hand, we supply a hook which can be used when desired.

Generally, the differences of opinion among physicians who designate the type of arm the child is to have are based not on reliable evidence, but rather upon the ideas of old limb makers and the desires of parents.

My hope is that this important research and work program will be continued until we know how and when to prescribe the best devices to fit the needs of the child and to help him to make the best psychological and social adjustment to his handicap.

G. G. Deaver, M. D.
Medical Director of Children's Service, New York University, Bellevue Institute of Physical Medicine and Rehabilitation.

WASKOWITZ: Dynamic Help

The story of "Foster Family Care for Emotionally Disturbed Children" as told by Verna Waskowitz of the Family and Children's Society of Baltimore, ("Foster Family Care for Emotionally Disturbed Children," CHILDREN, Vol. 1, No. 4) marks a milestone in the history of the development of foster care and has important implications for the child-placement field as a whole.

This article reveals the agency's conviction that the child's own family and own parents are vital to his growth and development. At the same time, it leaves the reader with the conviction that placement is not necessarily a discouraging "last resort."

Psychologically this concept is most vital in implementing the placement worker's ability to help the child. Only when placement is regarded as a helpful process to the child and his own family, to the point where they can unite and accept each other with greater tolerance and understanding, or can live apart more comfortably, does the social worker feel free to utilize fully the potentials of placement.

From the Jewish Child Care Association's special project for exceedingly traumatized children (several of whom have been diagnosed as psychotic), begun in 1950, we too learned that psychiatric help given to the child, along with intensive casework to him, his family, and his foster family, produce results which are encouraging.

Evelyn Spiegel
Director, Foster Home Department, Jewish Child Care Association, New York

Foster Parents Needed

The program of the Baltimore Family and Children's Service for emotionally disturbed children as described by Verna Waskowitz is an encouraging challenge to child-placement agencies.

The task of helping disturbed children who must live apart from their own families is an old and formidable problem, but as new insights are gained, new endeavors get under way. The recent developments in the establishment of treatment centers represent one type of effort; the specialized foster home is another. Others will come, as will refinements and clarification of methods.

An essential aspect of the program described by Miss Waskowitz is the greater responsibility assumed by the agency, through the caseworker, toward the foster parents. The worker not only is on hand when crises occur, but—what is essential—she anticipates and averts crises and emergencies.

One of the aims of the program is to strengthen the day-by-day living experiences for the child in order that he may master new habits of feeling and acting. Just as houseparents in a treatment institution require a continuous educational program, so do foster parents if the goals are to be achieved.

This program, as well as general programs of child placement, is up against the fact that the lack of adequate foster homes is often the greatest obstacle in providing good care for children. As a result of this lack, many children become emotionally disturbed under agency auspices.

Traditional methods of recruiting foster parents are not sufficiently effective. The search for *specialized* homes requires new assumptions and new methods which will contribute not only to the welfare of the special child, but also to the welfare of the other children cared for by a child-placing agency.

Lois Wildy
Illinois Children's Home and Aid Society, Chicago

WITMER: Community Climate and Delinquency Control

An outstanding quality in the discussion of parental responsibility for juvenile delinquency reported by Helen Witmer ("Parents and Delinquency," CHILDREN, Vol. 1, No. 4), was the humility with which these well-qualified persons approached their task. None of the discussants maintained that his special approach is the final or basic solution to the complex problem of delinquency.

As Mr. Lourie and Dr. Bloch both indicate, our lack of specific knowledge and techniques prevents us from pinpointing our treatment efforts more effectively. However, a highly important factor in delinquency control is the

community climate—whether it is understanding or hostile, whether it recognizes the problems of the so-called marginal families, or rigidly imposes middle-class standards that they cannot attain. Authority, both of law and of community standards, is of key importance in reaching such families, but it can be highly destructive, too, if it arises out of workers' frustration or bureaucratic impatience with the vagaries of human behavior or the apparent "orneriness" of individuals with deep-seated problems. Much depends on *motivation* for the use of authority.

While agreeing with Dr. Shaw's contention that clinics have geared their approaches to middle-class problems, I cannot go along with the implication that this a static situation. Under the impact of integrated, community-wide programs such as the one we operate in New York City there are clinics and social agencies which have either moved, or showed potentalities for movement, away from such a position. It is important for progress that this be recognized. Likewise while I cannot quarrel with Dr. Shaw's analysis of the community's role in either fostering or preventing delinquency, this viewpoint must not be overstressed to the point of neglecting improvement of individual treatment services, as can well happen in the enthusiasm that the area-project approach engenders and even demands. Like other proposed solutions, the area-project approach is not the total answer.

Ralph W. Whelan
Executive Director, New York City Youth Board

YUM: Extended diagnostic service

The description of the nursery-school activities at Michael Reese Hospital is excellent ("A Nursery School for Cerebral-Palsied Children," by Louise Yum, CHILDREN, Vol. 1, No. 4). It includes many ideas and activities which can be carried out in other nursery schools, and which are basic to the socialization and development of school readiness of cerebral-palsied children.

As I read the article, however, I hoped that there might be some indication that the observations made by the staff might be relayed to the teachers receiving them in more advanced classes. Ideally, teachers should be given opportunities to observe children in their nursery-school activities and to discuss the evaluations of their progress with those who have dealt with the children in the nursery-school class.

Again I feel that we might well place more emphasis on the function of the nursery school as an extended diagnostic service. This was implied in the article, but I hope that in other reports on similar projects this aspect of the program can be pointed out more definitely. The success of educational programs for the cerebral palsied must depend to a great extent on evaluation of children's needs and abilities as they may be obtained in the nursery-school class. This can be achieved through observation, diagnostic teaching, and the frequent meeting of medical, therapeutic, psychological, and educational personnel to discuss the progress of the children: I am sure that this is what goes on at Michael Reese.

My congratulations to the author and to the Children's Bureau for making this type of material available.

Arthur S. Hill
Educational Director, United Cerebral Palsy, New York

HOCHFELD: Long-Distance Casework

The American caseworker, faced with the variety and complexity of unknown forces operating in what Eugenie Hochfeld calls "long-distance casework," ("Problems of Intercountry Adoption," CHILDREN, Vol. 1, No. 4), needs great inner security to accept her limited role. The worker has to recognize that her part is a small one, but if she carries it with full responsibility it may be very significant.

If we recognize the purpose of the law, as intended for the real benefit of many children, and if in spite of its deficiencies we make the best use of it, we may be sure that it will accomplish great good.

We know mistakes will be made. There will be some heartaches when we are dealing with human beings. This happens even under the best and most controlled circumstances.

The evidence already available indicates a higher percentage of success than could have been predicted. But the anxiety of private agencies could be greatly reduced if there could be provision for public support of children for whom they are unsuccessful in planning.

Through cooperation with International Social Service, American social workers can learn a great deal that can be applied to our practice in the United States. Our experience in intercountry placement may help some of us to be less fearful of life.

Eleanor W. Gordon
Formerly Director, Child Placing and Adoption Committee, New York State Charities Aid Association

CLOSE: Confirmation of Travelers Aid Experience

It is heartening to read in the story of the Conference on East Coast Migrants ("Combining Forces for Migrant Children," by Kathryn Close, CHILDREN, Vol. 1, No. 4) of the steps taken to better the conditions of migrant agricultural workers. Travelers Aid Societies, while not located adjacent to the farms on which this "stream" lives and works, see the effects of the difficulties and conditions encountered by families as they move about seeking work or striving to return home. Often traveling independently of crews they come to centers of populations where Travelers Aid Societies are located. These families present many problems, but especially noticeable are the results of child labor, insufficient educational and recreational opportunities for children, bad housing and sanitation, inadequate incomes, and inadequate child care.

In contrast to many people seen by Travelers Aid Societies, migrants move within a reality based pattern for practical reasons rather than out of "flight" from emotional problems, and service to them must be based on recognition of this fact. However, discrimination against the nonresident whose presence in a State has frequently been encouraged by governmental agencies often blocks constructive help by closing local resources to them.

As the report of the conference points out, the problems of migrants touch many facets of social organization, and their solution will not be found in any one answer. Legislation providing necessary financial assistance and medical care, acceptance by communities, including schools and employers, availability of social agency's services, voluntary as well as tax-supported, are all important. The initiation of the project on East Coast migrants to unite the interests of many forces, both governmental and voluntary, seems at last to provide a constructive approach.

Margaret Creech,
Director, Department of Information and Studies, National Travelers Aid Association

All the problems of growing up come into the focus of staff physicians at . . .

A CLINIC FOR ADOLESCENTS

J. ROSWELL GALLAGHER, M. D.
Chief, The Adolescent Unit, The Children's Medical Center, Boston

ADOLESCENTS being neither little children nor adults, their needs, their interests, their attitudes, and even some of their physical ailments differ both from those of younger and from those of more mature people. Why then, would their medical needs not best be cared for in a setting devoted exclusively to them?

Believing that an affirmative answer to that question is the correct one—believing that *adolescents are different*—Boston's Children's Hospital has established an outpatient and hospital service designed exclusively for the care of boys and girls from 12 to 21 years of age. This Unit is devoted entirely to the treatment and study of young people and to the training of physicians in the care of adolescents.

For many years we have had hospital services devoted to little children and others for adults. Adolescents fit awkwardly in either of those services, no more at ease next to a sniffling 8-year-old or to a crib than to adults recuperating from a hysterectomy or prostatectomy. Not only are adolescents uncomfortable when grouped with such companions, but so too will be their physician unless he can readily change his manner, and his mode of treatment.

Adolescents will be more comfortable in a place of their own, and their physician will be more effective if he has readjusted his thinking to fit their needs. Not what upsets a child or an adult, but what is most likely to upset an adolescent, must be on his mind. Not how to manage obesity or menorrhagia or hypertension or backache in a 50-year-old, but in a 15-year-old, must govern his judgment if he is to serve his patient best. Being different, adolescents require different management.

Heretofore adolescents have not been the special concern of either the pediatrician or the internist. They have not been neglected, but they have not had the special attention which we have given to other age groups. Yet it is fitting that they should. These young people are at a crucial point in their lives, a time when the kind of care they receive can make a tremendous difference. Good care they have to have, but the best of care they can only hope to get by our developing services exclusively for them—facilities where their requirements and ways of fulfilling them can be studied and where a physician can acquire additional knowledge about them.

The Adolescent Unit established at the Children's Hospital in Boston in 1952 provides adolescents with a complete program of medical care. In this Unit, all manner of illnesses and problems which beset these young people are treated. It is not a specialty clinic. On the contrary it is a general-practice clinic, devoted to an age group rather than to a certain type of illness or to a single kind of problem.

All people between the ages of 12 and 21, regardless of their complaint, are offered help at the Unit. Boys or girls with stomach trouble or headaches or painful backs, those who are failing in school, whose eyes or ears are troublesome, or who cannot get along with people at home or at school, all come within the interest and province of the Unit's physicians.

Specialists' help is available for those adolescents who need it, but within the Unit, the specialist is primarily a supervisor, a consultant, a teacher. He may talk to and examine the girl who has menorrhagia, but after a discussion of this problem with

—Photos by Esther Bubley

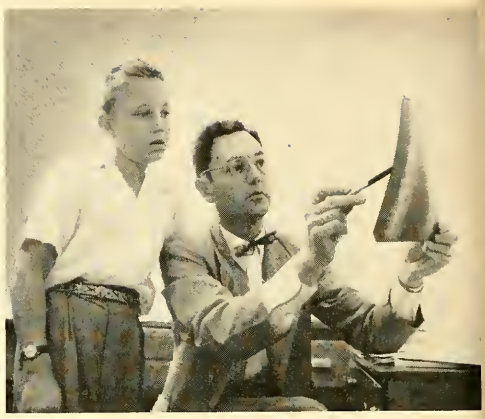
her physician, he will in almost every instance leave her future care and management to him. Whenever a patient requires special techniques or the advantage of the special skill which a specialist possesses, the patient is referred to that specialist and to his service for study, treatment, or even for long-continued care. However, whenever the adolescent can be satisfactorily cared for by the physician who is trained in the care of members of this age group, the patient remains with him. In this way a close personal relationship is developed and maintained between the physician and the adolescent, with the emphasis kept on the person and not the ailment. However, when the patient requires surgical or ophthalmological, psychiatric, or orthopedic care, or other treatment best obtained under a specialist's management or in a special clinic, a transfer is made.

The Unit attempts to fulfill four main objectives. Its primary purpose is to offer young people their own outpatient clinic and hospital facilities and their own physician just as for many years little children and adults have had theirs. Secondly, it was developed so that physicians might have an opportunity to become trained in handling adolescents and so become familiar with the medical and emotional problems which commonly affect these young people. The third objective is to provide research workers with a single setting as a focus for their studies in the health problems of this age group—a place where the representatives of a variety of disciplines might bring their various skills to bear on adolescents' problems. And lastly, the Adolescent Unit was established so that physicians might have an opportunity for training in the *care of a person* in contrast to training in the *management of a problem*.

Special Concerns

Although the Unit is interested in the great variety of illnesses, injuries, and emotional and behavior difficulties exhibited by young people, its staff attempts to keep in mind four special concerns significant to all adolescents, no matter why they come for help.

The first of these is the adolescent's concern with his or her own growth and development. Size makes little difference to a child or to an adult, but to be too short or too tall, too fat or too thin, or to mature less rapidly than one's companions are matters of considerable importance to an adolescent. Young people want to be average and they want to be sure they are normal. But they have little understanding of either of these terms, and little or no understanding of the wide variation in the rate, extent, and time



Respecting a young person's normal desire to understand his problems is a primary policy of the Adolescent Unit at the Children's Hospital in Boston. Here one of the Unit's physicians interprets an X-ray film of a knee injury to a patient.

at which perfectly normal young people grow. Frequently when they deviate from what they believe is the normal, they become anxious and develop symptoms which simulate illness.

A second concern grows out of the adolescents' habit of strenuous living. They don't just play around any more as little children do, and they don't sit in a chair all day as do many adults. They go at things hard, they go at things to win, and their questions to physicians in regard to the fitness of their backs or knees or hearts need to be answered with due attention to the fact that they live strenuously. They do not ask whether their hearts are fit for office work or playpen; they ask if their hearts are fit for a mile run or soccer. In connection with this, the physician needs to remember the effect which restriction of their normal activities can have upon them.

Thirdly, the Unit's staff keeps in mind both the adolescent's concern with school and the school's effect on the adolescent. Though young people are often not very fond of school, it nevertheless affects their lives and sometimes their health. Most adolescents want to succeed, and when their schoolwork goes poorly, this fact may account for their upset stomachs or their headaches. Not to have school in mind, not to question them about it, not to determine their attitude toward it, is to leave out a very important potential cause of many symptoms usually associated with illness.

And finally, the Unit keeps in mind a number of other concerns which commonly cause adolescents

anxiety: confusion about death or religion; the acquisition of independence; sex; conflict in the home; acceptance by their contemporaries; and the assumption of adult responsibilities.

In addition to the special concerns characteristic of adolescence, young people suffer illnesses and injuries peculiar to or very common in adolescence. Observation of these is important in the training of practicing physicians and in research directed toward a better understanding of adolescents. We need more knowledge of these illnesses and of adolescents' reactions to them, in order to solve problems in endocrinology, in the prevention and care of athletic injuries, in the management of adolescents who are handicapped by diabetes, epilleptic seizures, acne, in a variety of emotional difficulties, and in such conditions as epiphysitis of the spine and in dysmenorrhea and menorrhagia, to mention only a few.

Program

The Unit was opened in the fall of 1952. Since that time it has grown rapidly so that it now handles more than 500 patient visits a month. The young people are referred to the Unit by family physicians, specialists, social agencies, public and independent schools, colleges, and guidance centers. They come not only from Boston and other parts of Massachusetts, but from many other sections of the United States and even from foreign countries. The Unit's staff and its quarters are being expanded as rapidly as possible to take care of an increasing demand.

Desks are taboo in physicians offices at the Adolescent Unit as bars to an informal atmosphere. The kind of easy relationship, achieved by the physician and patient pictured below is fostered to help the physician see the person behind the problem.

In addition to providing facilities for the diagnosis and care of medical and emotional disorders, injuries, and surgical conditions, the Adolescent Unit has already inaugurated some programs which reach outside the hospital walls. It has interested itself in the health services of nearby social agencies and of such institutions as the Boys' Club of Boston. It has also developed a small division which devotes its attention to training teachers in methods designed to help young people badly handicapped in school because of a specific language disability and who, despite high intelligence, spell atrociously, read inefficiently, and even write and talk poorly. The division has been developed to meet a need which became increasingly obvious as more and more adolescents who came to the clinic for a variety of other reasons were found to be handicapped by this condition. It is hoped that its activity will prove not only to be of considerable help to many promising adolescents but also bring about a closer liaison between the educational and medical professions.

The Unit also offers training to physicians who intend to devote their time to the care of students attending public or independent schools or colleges. Few other opportunities exist for such orientation. The Unit's general practice setting, its staff's interest and experience in schools' medical problems, its school-age patients, and its cooperation with nearby schools and the Harvard University School of Public Health all combine to make possible the offering of a well-rounded training program to physicians who would be school doctors.

The Adolescent Unit is not a specialty clinic. Neither do those who are planning its program have in mind the training of physicians who will subsequently be considered as specialists in the field of adolescence. On the contrary, the Unit offers training to general practitioners, internists, and pediatricians, not that they may become specialists, but that they may have an opportunity to learn more about adolescents and increase their skill in the management of those adolescents who will come to them in their later practice. Within the Unit itself, however, the teaching staff confines its attention to adolescents, though most of the consultants who participate in the training program care for patients from a variety of age groups in the course of their own practice.

The Unit's physicians who comprise its full-time teaching staff include those whose previous experience has been in general practice, internal medicine, and pediatrics. The consultants and special-

ists who train these men as well as physicians at the Unit for a temporary period of training, are experts in endocrinology, gynecology, cardiology, dermatology, psychiatry, ophthalmology, orthopedics, neurology and other branches of medicine. As the Unit's staff and facilities expand, experience with, and training in the management of health problems in adolescents will be extended to those of the hospital's house officers who wish it, to medical students, and to practicing physicians who apply.

The Unit's research program is in no more than the planning stage. Preliminary studies of the incidence, causes, and management of dysmenorrhea have begun. The problem is being approached from the clinical, the laboratory, and psychological points of view. The Unit is also accumulating data which will be helpful in outlining an extensive study of the interrelationship and relative value of serum cholesterol, protein-bound iodine, and the basal metabolic rate in the diagnosis and management of hypothyroidism in young people. The Unit is also planning a long-term study of adolescents with a considerable degree of systolic hypertension.

Another major research project under discussion is a long-term study of the causes, the early recognition, and methods of remedying specific language disability. The investigation of this subject contemplates a multidiscipline approach utilizing knowledge of genetics, neurology, education, psychology, hematology, and electroencephalography.

The Unit has already installed equipment to test the value of a new photographic technique in such fields as growth and development, orthopedics, and constitutional medicine. This is in line with our general intention to confine our research activities to inquiries which have clinical applicability to the patients who come to the Unit and which are best investigated in a setting offering large numbers of adolescents for study. In many instances our research will be carried out in collaboration with other departments of the Children's Medical Center, the Harvard Medical School, and Harvard University, and, occasionally, other institutions.

Though it's done with mirrors there's no trick at the Adolescent Unit in the careful recording of changes in body structure. This procedure was adopted in recognition of rate-of-growth not only as symptomatic of health or ill-health but also as of great importance to the young person's feeling about himself.

Sam

There may be no better way to make clear both the need for these young people to have a clinic of their own and for physicians to have the opportunity of receiving training in their ailments and their characteristics than to tell the stories of a few of the Unit's patients.

Sam first came to our clinic when he was 15. He was brought in by his very excited and nervous mother because she had been told that he had signs of heart disease. The physician to whom Sam had previously been referred, though reluctant to make a definite diagnosis of heart disease, had suggested the importance of reevaluations of his heart at regular intervals and had urged a strict curtailment of his activities.

A brief talk with Sam's mother at her first visit to the Adolescent Unit yielded nothing in the way of history to suggest heart disease in the boy or other members of his family, but it did give the Unit's physician the opportunity to appreciate her great anxiety and to become aware of the constant supervision which she was now exercising over her son. She explained that he had been thoroughly examined, that he had been fluoroscoped and that electrocardiograms had been taken and that complete laboratory studies had been made. Three or four repeated examinations had, according to their doctor, revealed no change in his general condition, and she now wanted to be assured that nothing more could be done.

Sam's general appearance was that of a normal, healthy boy. Nevertheless his anxiety was obvious as was his relief when he discovered that his mother was not going to participate in his visit with the doctor nor be present at his physical examination.

Taking an aptitude test, this girl is helping the doctors learn something of her native abilities—important to their understanding of whether frustrations in school or at home may be causing the symptoms that brought her to the clinic.

After he had been asked the usual questions about his previous health and about the presence or absence of a variety of symptoms, and had told of his interests, his summer activities, and his future plans, he was considerably more at ease. When asked whether he liked school or not, he talked freely and was able, without hesitation, to describe his feelings about his young, attractive teacher. Finding his doctor listening without being shocked or critical, he went on to explain how his heart would sometimes pound and how he would have very guilty feelings because of his thoughts and actions. Allowed to talk, it was not long before he burst out with: "I was terribly scared when I went to those doctors. I was afraid they would find out. It *is* bad to masturbate, isn't it?"

Sam's physical examination showed nothing of any importance. Even his heart rate, which had been considerably accelerated at his other recent examinations, and which was the primary reason for physicians suspecting that he might have some heart disease, was well within normal limits. What Sam really had was anxiety. He was confused and guilty about those feelings and thoughts of his and about his masturbation, and being in an anxious state, was beginning to wonder if perhaps he did have heart disease. After all, the doctors thought he might, and his heart did pound a great deal.

Variation from the normal character of heart sounds or of the heart rate or rhythm must not be overlooked, but it is important for physicians to remember that factors other than heart disease may be involved and that the worries which cause adolescents confusion and anxiety can also produce pain over the heart or a rapid beat. Given an adequate opportunity to talk alone with his doctor and away from his parents, the worried adolescent is usually quick to come out with the source of his anxiety.

"What kind of a person am I dealing with," is as much if not more important to the physician than the question: "What sort of heart disease could I be dealing with?"

Mary

On the other hand, it can be just as disastrous for the physician to jump quickly to the conclusion that an adolescent's symptoms are entirely "psychological." Up to her sixteenth year, Mary had got along beautifully both at home and at school. Then she gradually became more irritable, made nasty remarks with little provocation, easily broke into tears, and, according to her teachers, no longer seemed able to concentrate. Some of her teachers thought the trouble was "boys." Her mother, upset by a variety of other problems, had several explanations, but her favorite was that Mary was beginning to show a nasty streak and was becoming more and more like her father. A psychologist suggested that Mary was expressing long suppressed feelings of hostility against her mother and that she was also having difficulty reconciling herself to the process of becoming more feminine.

There was undoubtedly some truth in these observations. The mother was a very strong, efficient, and dominant person whose well-meaning interference it would be easy to resent; and a few minutes conversation with Mary brought out the facts that she was not interested in boys, but loved to play softball and field hockey, and to help her father work on the car—all of which though healthy enough in themselves, hardly indicated an avid desire to become more feminine.

Mary's father was the practical, hard-headed type. He stayed out of the discussion about her at first, but when she not only failed to improve, but actually became more and more nervous, he finally said he had "had enough of all this nonsense" and was going to take her to a doctor for a complete physical examination.

It is as easy to overlook the obvious when you see

a person daily at home or at school or at work as it is easy to detect the unusual in a person you have never seen before. Mary did not look like the sort of girl who would want to be nasty, but she certainly seemed to be excessively nervous. She stared, she could not sit still, her nails were bitten down to the quick. It was not surprising that her laboratory findings bore out the diagnosis which her very rapid heart rate, her excessive sweating, bulging eyes, and moderately large thyroid gland strongly suggested. Undoubtedly this girl was annoyed at her mother's bossiness and was not yet desirous of trading her basketball shoes for silver slippers, but her primary difficulty was hyperactivity of her thyroid gland.

A thorough inquiry into an adolescent's physical status, and due attention to the illnesses and physiological changes which are common in those years is just as important as attention to the psychological factors which can produce misleading symptoms.

Susan

Techniques of examination and treatment which are appropriate for an adult may be far from ideal for an adolescent with the same ailment. Similarly, the cause of the anxiety which accompanies the disease may not be the same in the adolescent as it is in the adult. Susan, who came to us with menorrhagia, clearly illustrates these points and the desirability of having a special setting for adolescent care. Her story shows the importance of offering physicians training to help them understand adolescents and the differences in the same illness when it is seen in the adolescent and when it is seen in the adult.

Since the beginning of Susan's menstrual periods 2 years previously there had been considerable irregularity, both in the interval between them and in their duration. On two occasions, the flow had continued for as long as 4 weeks. At the time we first saw her, her mother had become very worried because the flow had persisted for 28 days, and although on many of those days the flow had been scanty, it had become quite profuse during the previous 2 or 3 days. Susan's previous physician after he had thoroughly examined her—including a pelvic examination—had said that if this difficulty recurred, she should have a dilation and curettage.

Susan, an alert, attractive young girl, did not appear ill. She showed much less evidence of anxiety than did her mother. It quickly became apparent to the clinic physician in talking to her that such anxiety as she had arose from worrying that her symptom might keep her out of normal activities, and prevent her from returning to her summer camp. At her age, and at her stage of emotional development, this vacation—being away from home, with girls of her own age, swimming, horseback riding, mountain climbing—mattered much more to her than the persistent flow. The fact that she had menorrhagia did not bother her, but she *was* worried about the possibility that it might spoil her summer. An adult with this symptom would certainly be worried about the menorrhagia itself and its possible cause.

A thorough medical history, including a charting of Susan's menstrual periods, a physical examination—omitting a pelvic examination—a blood count including examination of the platelets and clotting time, and a tourniquet test were all that were necessary to form an opinion of the nature of her difficulty and make it possible to reassure her mother.

Once the Unit's physician could be sure that no blood dyscrasia was present, he could properly explain this disorder on the basis of the wide variations of menstrual pattern which occur in early adolescence. It was possible too, with his knowledge of variations in the physiology of this process in adolescence, for him to remove Susan's worry about her summer camp and to assure her that her difficulty could be controlled and that it need not interfere with her activity or bother her in any other way. To do this, and to spare her the discomfort and emotional reaction she might have had from pelvic examination or instrumentation, were tremendously important from the standpoint of her future attitude toward sex and femininity. For her to associate normal biological processes with discomfort, disappointment, and distaste, would be most unfortunate. It was clearly of importance here for the physician to keep in mind the sort of things which upset and worry an adolescent, as well as the physiology associated with her symptom and the methods of examination and treatment appropriate for a young girl.

The physician treating adolescents must be aware of their physiology, of the illnesses they are likely to develop, of their interests, and of the things that confuse and upset them. These are not identical with the ailments, the physiology, the worries, or the emotional reactions of either little children or adults.

Though the Adolescent Unit cares for, studies, and gives training in the treatment of young people who have acne, athletic injuries, obesity, poor nutrition, headaches, or indigestion, failure in school, rebellion, hernia, heart disease, poor reading skill, or asocial behavior, the focus remains on the person, not the problem.

A prenatal clinic tries mental health concepts and the teamwork approach in . . .

PREPARATION FOR HEALTHY PARENTHOOD

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FOR THE PAST 3 YEARS the Department of Maternal and Child Health of the Harvard School of Public Health has been exploring the possibilities of a team approach to the provision of health services to families, beginning early in the wife's first pregnancy. The team consists of specialists in obstetrics, pediatrics, nutrition, psychiatry, social work, and public-health nursing. It attempts to uncover in initial stages any physical or emotional factors which might disturb family health and stability, and to remedy them before they have done serious harm.

While it is too soon to present conclusive results from these family studies, an account of the clinical experiences of the team in dealing with some typical emotional problems which have emerged will illustrate a kind of mental-hygiene service for young people approaching parenthood made appropriate by present-day knowledge.

The team first meets the families in a prenatal clinic, and later, after the birth has taken place, maintains contact with them in a well-baby clinic. During pregnancy, the expectant mother, often accompanied by her husband, makes 10 to 12 regular visits of about 2 hours' duration to the clinic. She sees the obstetrician and the public health nurse on each occasion, and in addition one or more of the other specialists. Each of these last routinely schedules two or more interviews with her during the course of her pregnancy and increases the number if he feels that extra service is indicated or if the patient requests it. The public health nurse routes the patient to the different interviewers and helps her learn the professional roles of the various workers, usually a rapid process. The services of the specialists are coordinated at pre- and post-clinic conferences where each patient is discussed and her treatment plan laid out. Experience has shown that this system leads to the development of an affectional tie between each family and the clinic as an institution, as well as to individual relationships of varying intensity with each of the specialists.

Significantly, in this project the mental-hygiene work has not been regarded as solely the province of the psychiatrist, but involves each team member. At first, for about a year and a half, the psychiatrist saw the expectant mothers and their husbands routinely—mainly in order to collect research data. Except in a few instances of special complexity, he did not himself intervene psychotherapeutically, but used his findings to help the other specialists plan the management of their cases. After his data had been collected, he began operating solely as a consultant to the other team members, having no direct contact with the patients. All the workers have become alert to the implications of their specialized work as regards the emotional life of their patients and consult regularly with the psychiatrist in order to work out the mental-hygiene techniques appropriate to their specific functions and each expectant mother's individual emotional needs.

The team as a whole also operates in many instances as a mental-health unit with a defined aim. This is achieved by building up an appropriate

emotional atmosphere through conscious attitudes towards each patient arrived at during the post-clinic conferences. The general role of the team unit is similar to that of a good mother. The patient is made to feel that her individuality is respected and accepted. At certain stages of pregnancy some expectant mothers are allowed to become very dependent on the clinic team as a whole or on specific members, but at all times emphasis is unobtrusively placed on the patient's adult status. She is encouraged to ask questions and to express doubts and differences of opinion. Suggestions and criticism on the running of the clinic are solicited. All members of the team have learned to listen patiently.

The rationale behind this supportive approach is that in addition to helping to bolster the psychological strength of the patient, it involves the expectant mother, as recipient, in an experience similar to a healthy mother-child relationship. The hope is that she may relate to her child in the same way that the team unit does to her. In cases where the patient has never experienced such attention from her own mother, this therapeutic approach is intensified and is continued during the first few months of the child's life.

The behavior of the team members usually leads to the rapid growth of a confiding, trusting attitude on the part of the patients. Occasionally this turns into extreme dependence during the later stages of pregnancy and in the lying-in period. After the young mother has learned to care for her baby with some confidence her attitude to the clinic team becomes one of friendly cooperation on an adult level.

The patient's positive feeling facilitates the collection of important information about her emotional life. It is also valuable in motivating her to accept advice on health habits. Nevertheless, some instances of difficulty in cooperation have arisen, particularly in relation to changing food habits.

Difficulties

The importance of adequate nutrition during pregnancy for the production of a healthy baby leads the clinic to place strong emphasis on correct diet. The dietary advice given by the obstetrician or the nutritionist usually comes at a time when the metabolic processes of pregnancy produce an increased desire for food, and therefore often meets with some, and occasionally with great, resistance on the part of the patient. This often comes from a patient with a history of childhood feeding battles provoked by a difficult relationship with her mother. Sometimes such patients can be helped by being shown how they are incongruously transferring the old pattern of fighting against mother onto the nutritionist and obstetrician. Sometimes it takes other members of the team with whom they may have a more positive relationship to get them to see the importance of a correct diet—an example of the use to which the patients' various types of relationships to the team members can be put. So far no patient has consistently ignored every member of the team.

Another type of patient who has especial difficulty in following the advice of the nutritionist is the expectant mother with predominantly negative attitudes towards her pregnancy. Experience shows that understanding, patience, and sympathetic support help many of these women to free themselves sufficiently from the burden of their mixed feelings to allow them to control their eating habits. The more they can be helped to express their negative feelings verbally, the less do they need to act them out.

It is extremely difficult for non-psychiatrically trained workers to understand and control their own natural feelings of frustration in respect to the uncooperative patient, particularly in the case of the immature, self-centered girl who appears to be rejecting her pregnancy for purely selfish reasons. One of the strengths of the clinic has been the team spirit, which has supported the individual workers so that they have been able to express these feelings in case conferences. They obtain the help of the group in overcoming them, so that they can be free to understand the human problems of the patient and find a constructive approach to them.

Apart from producing a general therapeutic atmosphere, the main mental-hygiene efforts of the clinic team are focused on trying to identify, and wherever possible predict, situations of emotional crisis. The patient is then helped to deal with her problems in a healthy way.

A frequent problem is presented by women who have to adapt to an unexpected and often inconvenient pregnancy. Few of the young women attending the clinic have consciously planned their pregnancy. In many cases its discovery is followed by a period of emotional upset. Most of these distressed women spontaneously get over the initial upset. By the third to fifth month they accept the inevitable, and develop a positive attitude to the pregnancy. Some feel very guilty because of their initial rejection of the baby and need help in verbal-

izing and reducing their guilt feelings. Unfortunately, their sense of guilt has often been increased by reading mental-hygiene literature on the danger to the child of a rejecting mother. Experience up to the present shows little relation between such initial rejections of the pregnancy and disturbed mother-child relationships.

In some cases the woman's guilt is directed towards her husband, because her pregnancy interferes with his plans for a career. In these instances it has not been unusual to find indications that despite her conscious agreement to postpone childbearing an underlying desire to have a baby was responsible for the "accident." Here too guilt must be uncovered and reduced by the social worker or the psychiatrist, lest it pervert the future relationship to the child.

In another type of case the patient's psychological equipment is not yet mature enough for motherhood. In such instances, the woman is often an overdependent, deprived person. Sometimes her husband consciously or unconsciously initiated the pregnancy against her wishes, and later showed signs of taking over the mother role for which she was unprepared. With such women the reproductive experience often has a maturing effect, as it does on other women, but the health workers have to be constantly on the alert for early signs of disturbed relationships between mother and child.

One such woman began in her seventh month to complain that the baby was becoming a burden, because its kicking was keeping her awake at night. When this subject was discussed with her by the psychiatrist she recalled memories of late childhood, when she was forced to take care of her younger brothers and sisters so that her mother could go out to work. The psychiatrist showed her how she was preparing to transfer her negative feelings toward her burdensome siblings onto her new baby.

In many cases pregnancy seems to stimulate the revival of old emotional conflicts, particularly in regard to unsolved childhood problems of relationships with parents and siblings. This provides an opportunity for the achievement of a new and more stable mental equilibrium. The active emotional support of the clinic workers helps the patient to feel secure enough to come to terms with her conflicting feelings in a more positive way.

Women whose early rejection of pregnancy led them to plan or unsuccessfully to attempt abortion are treated with great care. Previous work has shown how unsuccessful attempts at abortion can easily lead to the building up of pathological anxiety and guilt which produce a specific disorder in the relationship between the mother and her child. The instances encountered so far in the clinic have been dealt with as early as possible. The patient is encouraged by the obstetrician or the caseworker to discuss her act at length, and efforts are made to reduce her excessive feelings of guilt and the consequent fear that she has damaged the fetus and will give birth to a deformed baby.

Mother Love

An interesting finding regarding the early development of the mother-child relationship may here be mentioned. The first manifestations of this link reveal themselves not only in the expectant mother's attitude to conception and pregnancy, but also in her feelings towards the fetus inside her and in her fantasies of the baby-to-be-born. Sometimes very early in pregnancy, but usually after "quickening," women develop love for the fetus which they have come to regard as a little person, and this love may continue unchanged after birth. One such mother said that when she first saw her baby, she knew that it was the person who had been inside her for 9 months. "He was very homely, but his appearance and his behavior were not important—I knew he was mine and I had loved him from the beginning—I didn't need to get to know him." This patient had spent little time during pregnancy daydreaming about what the baby would be like after birth.

Other pregnant women have no positive feelings towards the fetus. They may complain of their discomfort at its movements, and though intellectually they know it is a live being, they cannot conceive of it as a person.

The content and emotional coloring of the fantasies about the expected baby do not appear to run parallel to the feelings about the fetus. In each case, the clinic workers attempt to record the changes in these various attitudes during the course of pregnancy. It is hoped that this data may one day be of predictive value. Meanwhile, the patients are supported in their positive feelings and given a chance to talk freely about any negative attitudes. The resultant release of whatever guilt feelings they may have helps to keep their anxieties within comfortable limits.

Patients are warned in advance of possible changes in their feelings. This is especially important in regard to the emotional time lag after birth, which may last from 3 to 7 days. If during this period the mother experiences no maternal feelings towards

her infant, she is likely to be considerably upset unless she has been told beforehand what to expect. Anxiety at this time is especially inconvenient since it may impede the mutual adaptation of mother and baby to the nursing experience.

In an attempt to shorten this emotional time lag and to smooth her early efforts to relate to the baby as a person, the pregnant woman is encouraged to talk about the concrete aspects of baby care with the nurse and the pediatrician. Special attention is given to such problems as breast feeding, preparation of the layette, and plans for home help. These practical discussions help the mother not only to deal with her emotional reactions, but also to build up a real conception of her future role and to work through some of her anxieties ahead of time.

It is not yet known at which stage of pregnancy such talks should begin. Perhaps, like sex instruction for children, they need to be conducted differently at different stages, because their significance changes. While in most cases women show little interest in problems of baby care during the first trimester, sometimes just talking about babies at this stage helps an ambivalent patient adapt to the reality of pregnancy.

Casework Service

Most of the young parents studied were having economic and social problems more closely connected with the difficulties of starting a family in our culture than with the factor of pregnancy. Pregnancy, however, often aggravates these problems, and is in turn affected by them. Occasionally, the expected baby is in danger of being made the scapegoat for thwarted ambitions or the battleground for marital strife. Casework service to the parents is valuable in averting such an outcome. Young parents are not only stimulated by the clinic's social worker to mobilize their best efforts in dealing constructively with their difficulties, but are discouraged against allowing these problems to become connected emotionally with their relationship to their child.

A difficulty directly attributable to the pregnancy commonly results from the change in sex life. To ensure free communication and understanding by both husband and wife of the issues involved the social worker explores the subject with them in individual and joint sessions. The anxieties, insecurity, and guilt which not infrequently follow when sexual desire and capacity are impaired, are not hard to deal with, but can cause a lot of unnecessary suffering if ignored.

So far, this account has dealt almost entirely with the problem of the expectant mother, as indeed it should, since she is most directly affected by the reproductive process. The expectant father, however, is also important, as is the interaction between the marital partners. Therefore, the clinic makes a point of seeing all husbands at least twice during the pregnancy. Most of the husbands visit the clinic with their wives more often. Certain problems are routinely discussed in joint sessions.

Husbands are encouraged to participate as fully as possible in preparations for the baby, and their own emotional needs are taken into account.

The emotional changes in their wives, brought about by the pregnancy, are particularly and fully discussed with them.

On the basis of this understanding, their help is enlisted to deal with difficulties that may arise. Most husbands are gratified to be given the opportunity to contribute towards a smoother pregnancy. The expectant mother's increased passivity, her mood swings, her emotional irritability, and emotional lability are very important to them. When a man learns that these none too pleasant reactions in his wife are normal manifestations of the internal upheavals of pregnancy, his anxieties are allayed, so that he is able to offer sympathetic help instead of showing annoyance at her "acting up."

The husband who is afraid of "spoiling" his wife during her pregnancy because he correctly diagnoses regressive behavior, can be helped to appreciate his wife's need for increased love and support at this time. He can then realize that during her emotional preparation for motherhood she needs "spoiling" just as she needs an increased supply of vitamins and protein in her diet. This understanding enables him to offer his services with the feeling that he too has a significant role to play.

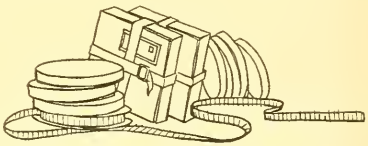
The clinic workers tactfully recognize the possibility that the husband may not quite like the fact that during pregnancy his wife rather than he holds the center of the stage at home. They may also prepare him to cope with feelings of jealously which may appear with the arrival of the baby. A joint discussion with the social worker allows both prospective parents to talk over and reduce their anxieties regarding the change in their relationship with each other which the approaching birth will inevitably entail.

The last few weeks of pregnancy are often the most difficult time for both husband and wife. Be-

cause the expectant mother's physical discomforts are usually increased at this time, she is apt to feel rebellious against the burdens of pregnancy—"always having to wear the same clothes, not being able to run upstairs or take part in ordinary social life, and the drag of this long waiting period." She often becomes more demanding at home and is irritable and disgruntled. A chance to express these negative feelings freely and to be assured of their normality is very helpful to her. If the couple has previously been warned of this phase, the wife will be less anxious and guilty, and her husband will be readier to give her the necessary support.

Superstitious fears about death during delivery or giving birth to a deformed baby may appear at any stage of the pregnancy and are sometimes increased in these last weeks. They are dealt with by being very freely discussed by the obstetrician, the nurse, or the social worker and are never perfunctorily dismissed with blanket reassurance. Instead, the mother is told that such fears are universal and that they may well persist despite her understanding that they are not based in reality, but may be a heritage from former days when many women did die during delivery. True reassurance comes to the mother when she realizes that the specialist recognizes the genuineness of her feelings, but is not made anxious by them. The mental-hygiene efforts of the clinic team have been intensified during the labor and lying-in period, but space does not permit description of this phase of the work. Suffice it to say that in their efforts the team members are ruled by the same principles as during the prenatal period: understanding the patient's individual needs; giving her emotional support; and providing her with calm, nonauthoritarian guidance based on an increasing knowledge of the range of factors leading to healthy adaptation of parents and children.

FILMS ON CHILD LIFE



Films listed here have been review by staff members of the Children's Bureau. The listing does not constitute endorsement of a film, but indicates that its contents have merit. Charges for rental or purchase, not given because they change, may be obtained from distributors.

THE FAMILY. 20 minutes, sound, black and white, 1952, purchase.

The unity of a family with modest resources is strained by conflicting individual aspirations, but is strengthened when the parents and the young people get together and admit their mistakes.

Audience: Parent or student groups.

Produced by: Herbert Kerkow Productions for the U. S. Army.

Distributed by: United World Films, Government Films Department, 1445 Park Avenue, New York 29, N. Y.

A TWO-YEAR-OLD GOES TO HOSPITAL. 45 minutes, sound, black and white, 1952, purchase or rent.

A little girl's reactions to an 8-day stay in the hospital show some of the effects of her temporary separation from her parents. Because this film was part of a research project the child was photographed at the same time every day to secure a "daily time sample." The English hospital procedures depicted are in many respects different from those in American hospitals.

Audience: Professional workers; students if time is available for discussion.

Produced by: James Robertson, at the Tavistock Clinic, London, England, in the course of a research project directed by John Bowlby, M. D.

Distributed by: New York University Film Library, 26 Washington Place, New York 3, N. Y.

DR. SPOCK. 27 minutes, sound, black and white, 1953, purchase.

Suggestions to parents on taking care of children of various ages, from early infancy to school age, are presented in an encouraging and reassuring way by Benjamin M. Spock, M. D., of the Western Psychiatric Institute, University of Pittsburgh. The film shows children in typical situations—eating, playing, and sleeping.

Audience: Parents and persons who work with children.

Produced by: March of Time.

Distributed by: McGraw-Hill Book Co., Text-Film Department, 330 West 42d Street, New York 18, N. Y.

SKIPPY AND THE 3 R'S. 29 minutes, color or black and white, 1954, purchase or loan.

The teacher of a first-grade class skillfully sparks the children's interest in learning to read, to write, and to count. They learn because they find a need for learning.

Audience: Parents; citizen groups.

Produced by: National Education Association and affiliated State education associations.

Distributed by: National Education

Association, Division of Press and Radio Relations, 1201 16th Street NW., Washington 6, D. C (purchase); and State education associations (loan).

AND NOW MIGUEL. 62 minutes, sound, black and white, 1953, purchase.

This is a picture of life on a sheep ranch in New Mexico, and of 12-year-old Miguel's longing to grow up and help the older members of his family to care for the sheep. Lambing, the behavior of the ewe and her lamb, the shearing of the sheep—all are depicted with simplicity and integrity as are the boy's touching relations with his older brother, his father, and his grandfather.

Audience: Parents, teachers, other adults, and school-age children.

Produced by: Joseph Krumgold for the U. S. Department of State.

Distributed by: United World Films, Government Film Department, 1445 Park Avenue, New York 29, N. Y.

FOOD AS CHILDREN SEE IT. 18 minutes, sound, black and white, 1952, purchase or loan.

As the title suggests, this film presents the subject of meals from the child's point of view rather than from the adult's. Its lesson for adults: Observe how a child prefers his foods cooked; let him decide how much to eat, giving him a choice of two fruits, for example; and let him serve himself. At the same time, the responsibility of the mother to offer the child foods that contain the essential nutrients is stressed.

Audience: Parents of young children; students of child development or home economics; nurses, child-welfare workers, and others who work with parents.

Produced by: General Mills, Film Department, with the cooperation of the Rochester-Olmstead County Health Unit, Rochester, Minn., under the technical supervision of Dr. Miriam E. Lowenberg.

Distributed by: General Mills, Education Section, Department of Public Service, Minneapolis 1, Minn.

RURAL NURSE. 18 minutes, sound, black and white, 1954, purchase or rent.

In a country town in the Republic of El Salvador, in Central America, a government nurse helps the people with their health problems. Her work is part of a demonstration carried on with the assistance of the United Nations. The film shows the details of the nurse's day—the dust that she plods through, the lack of water in the homes she visits, the warm thanks she receives.

Audience: Citizen groups, teachers from the third or fourth grade on, student nurses and students of related professions.

Produced by: United Nations, Department of Public Information.

Distributed by: Same.

A LONG TIME TO GROW. 35 minutes, sound, black and white, 1951 (Studies of Normal Development), purchase or rent.

First of a series of three films showing school experiences in early childhood, this picture shows little children in nursery school. A psychologist points out the interests and capabilities of the children, and evidences of their growth. The film shows clearly how the teacher is ready to give help when needed and to ease a tense situation without interfering with the children's spontaneous activity.

Audience: Parents, students, nursery-school teachers, and others interested in child development.

Produced by: Child Study Department of Vassar College.

Distributed by: New York University Film Library, 26 Washington Place, New York 3, N. Y.

NURSE MIDWIFERY—EDUCATION AND PRACTICE. 35 minutes, sound, color, 1952, purchase or rent.

A nurse who takes postgraduate training in midwifery becomes a certified nurse midwife and under a doctor's direction cares for women during pregnancy, labor, delivery, and the postpartum period, and also appraises the newborn infant. The picture indicates the various capacities in which certified nurse midwives function—as supervisors of obstetrical departments in hospitals, as instructors at schools of nursing, as consultants in maternity programs, as supervisors of licensed nonprofessional midwives, and as nursing specialists in public-health agencies.

Audience: Professional groups concerned with maternal and child-health programs; students in medical and nursing schools or schools of nurse midwifery; professional personnel in public-health agencies; students in advanced study of pediatric and obstetric nursing; schools of nurse midwifery.

Produced by: Alpha Film Productions for the Maryland State Department of Health.

Distributed by: Alpha Film Productions, 6000 Pimlico Road, P. O. Box 5325, Baltimore 9, Md. Available only as approved by the Maryland State Department of Health.

THE CHILDREN. 10 minutes, sound, black and white, 1952, purchase or rent.

This film shows how the United Nations Children's Fund (UNICEF) works in various countries to feed children and to protect them from disease.

Audience: The general public.

Produced by: United Nations, Films and Information Division, United Nations, N. Y.

Distributed by: Same.

THE COOL HOT ROD. 27 minutes, sound, black and white, 1953, purchase or rent.

A "smart" teen-ager who is going to wake up the slow town he has recently come to narrates the story. Having moved from a place where "hot-rodding" was synonymous with reckless driving in broken-down relics, this boy is surprised to learn that his new town, like many others all over the United States, has a constructive program of hot-rodding. He learns how the town's Hot Rod Club was developed, how the members run their converted stock cars on strictly supervised "drag strips," and how the cars are carefully checked for safety.

Audience: High-school students, teachers, and citizen groups.

Produced by: Sid Davis Productions, 3826 Cochran Avenue, Los Angeles 56, Calif.

Distributed by: Same.

THE MIRACLE OF REPRODUCTION. 15 minutes, sound, black and white, 1953, purchase.

Beginning with flowers, and proceeding through fish and other animal life, this picture moves on to human reproduction. It offers a number of photographs of young creatures to interest children, and uses animated drawings to explain methods of reproduction.

Audience: Young children—below the fourth grade—whose parents approve after having viewed the film.

Produced by: Sid Davis Productions, 3826 Cochrau Avenue, Los Angeles 56, Calif.

Distributed by: Same.

THE SECRETARY'S CONFERENCE ON JUVENILE DELINQUENCY

THE ATTACK on the problem of juvenile delinquency must be made on several fronts at once for there is no one remedy or preventive. This was made clear by the 475 persons who gathered together in Washington June 28–30 for the National Conference on Juvenile Delinquency at the invitation of Oveta Culp Hobby, Secretary of Health, Education, and Welfare. Coming from 43 States, the District of Columbia, the Virgin Islands, Puerto Rico, and Guam, they included police officers, judges, teachers, probation officers, clergymen, and representatives of public and voluntary social agencies and of a wide variety of civic, labor, fraternal, and religious organizations. They were asked: to take stock of the methods known to be effective against delinquency; to define the obstacles standing in the way of a successful antidelinquency campaign; and to formulate the steps to overcome them. They were invited, in other words, not just to listen to a "program" but to confer and to produce ideas and suggestions.

It was, therefore, a working conference, with thirteen work groups in all, each provided with a document—sent to the delegates in advance—to serve as resource material. These documents, issued by the Children's Bureau in cooperation with the Special Juvenile Delinquency Project, were the result of 2 years of work with lay and professional groups in assessing the causes of delinquency, what kinds of programs of prevention and treatment are needed, and how these might be achieved. They included among others *Police Services for Juveniles*,[1] *Standards for Specialized Courts Dealing With Children*,[2] *Training Personnel for Work With Juvenile Delinquents*,[3] *and The Effectiveness of Delinquency Prevention Programs*.[4]

Supported by private funds, the Special Juvenile Delinquency Project was established in July 1952 to help the Children's Bureau focus attention of the public on current problems of juvenile delinquency in order to stimulate action toward the improvement of preventive and treatment services. The conference was, in a sense, the culmination of its efforts.

The conferees met together in entirety only twice—at opening and closing sessions, with Dr. Martha M. Eliot, Chief of the Children's Bureau, presiding. At the opening session Secretary Hobby spoke of the tremendous increase of juvenile delinquency in the past 5 years and called for community and individual action based on "a deeper understanding of the enormous intricacy of this malady." Senator Robert C. Hendrickson, chairman of the Senate Subcommittee to Investigate Juvenile Delinquency attributed at least part of the "disparity between what is known about juvenile delinquency and what is done about it" to cleavages in the ranks of professional persons interested in the problem and called for united action among "teachers, judges, psychia-

The drawing at the top of this article is from "The Years Between," by Frances T. Humphreville and Ati Forberg. Scott, Foresman & Co., New York, 1953. Used with the permission of the publisher.

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trists, social workers, representatives of the press, and just plain citizens" toward its solution. Bertram M. Beck, director of the Special Juvenile Delinquency Project, reviewed the past 2 years of joint effort of the Project and the Children's Bureau.

Mr. Beck explained the details of conference planning, and, in accord with these plans, conferees spent the next 2 days in workgroups hammering out recommendations on the particular phase of the problem in which they had special interest. Each workgroup opened with a few remarks by a scheduled speaker to set the stage for the discussion, but from that point on the exchange of ideas flowed freely and informally and ocasionally even heatedly. By the end of the second day a committee of each workgroup had prepared a preliminary report which the group polished into an accepted form at its last meeting the next morning—no mean task in view of the variety of opinions that were presented.

At the closing general session Mr. Beck summarized the workgroup reports for the assembled conferees, and after some remarks of appreciation by Nelson Rockefeller, Undersecretary of Health, Education, and Welfare, the conference adjourned. This may have been more of a beginning than an ending, however, for there were already indications of followup conferences to come in a number of States and local communities, to stimulate the action called for in the workgroup reports.

The recommendations were many and varied but they underscored four basic needs: increased finances to provide the services and personnel involved in the prevention and treatment of delinquency; coordinated community effort to create a wider understanding of the intricacies of the problem; more and better-trained personnel in the public facilities and services that handle delinquent children; more knowledge about delinquency and the effectiveness of various types of programs.

The highlights of each workgroup's specific concerns emerge in the following article, a condensed version of Mr. Beck's summary for the conference.

STEPS TO COMBAT DELINQUENCY

BERTRAM M. BECK, M. A.
Director, Special Juvenile Delinquency Project

IT SEEMS APPROPRIATE to start with the workgroup concerned with counting delinquent children, for statistics are basic to public recognition of delinquency, to planning and evaluating prevention and treatment programs, and for designing research.

In this group present statistics drawn from data collected by the Federal Bureau of Investigation and the Children's Bureau were termed "fractional and noncomparable," and though useful in indicating trends, unable to give a precise picture of the volume or nature of the problem.

The group endorsed the Children's Bureau's efforts to select a national sample of juvenile courts for reporting statistics, and thus reduce the undue statistical influence of a single geographical area, or of highly populated areas. It also urged three technical improvements for future statistical recording: (1) use of "the child" rather than "the case," as the unit of counting, in order to avoid duplication; (2) development of a device to yield information about children who repeat offenses; (3) a sharpening of definitions, particularly those pertaining to unofficial cases.

This group envisaged the Children's Bureau as the nerve center of a national operation to collect comprehensive figures on delinquents from all agencies dealing with them, as well as certain aspects of program, such as cost and personnel. It also urged States to set up composite indices and localities to establish central registries, properly protecting the identity of each child, to provide an unduplicated count of children involved in delinquent acts, and so serve as the basis for informed public action.

This group recommended: that the Children's Bureau statistical staff be strengthened; that the States be urged to adopt legislation authorizing the collec-

—*Hardy for Dept. of H. E. W.*

Some of the 400 persons who registered at the conference. Each had been sent resource material ahead of time and been assigned to a workgroup in which he had expressed interest.

tion of uniform statistics; that the Bureau of the Census take a population count every 5 rather than every 10 years, so that more current child-population data would be available in calculating delinquency rates.

Prevention

While the double focus of the entire conference was on prevention and treatment, one workgroup was charged especially with considering how current knowledge about prevention might be applied. Out of its deliberations came a strong warning against looking for a single cause for delinquency or a single answer to the problem and an emphasis on the importance of interdependence of program, planning, and coordination. It called citizen knowledge and participation imperative to successful preventive efforts and pointed out that the efforts of family, church, and school, and of other social institutions, can aid in combating delinquency, just as their deficiencies or failures can contribute to the problem. While recognizing that fundamental knowledge about delinquency prevention is limited, the group stressed the need for community understanding of the current large body of knowledge based on experience with delinquents and study of normal growth and development.

While world, national, community and family problems are possible sources of personality tensions, their influence can sometimes be offset by helping individuals to understand their nature and achieve a balanced attitude toward them, this group reported. It also expressed a belief that children are not born delinquent, and that their proper guidance and protection is rooted in religious, spiritual, and ethical concepts.

Parents, its members said, must be helped to accept responsibility for discipline and guidance, but they added that measures to punish parents for their children's misdemeanors have not proved successful. This group stressed distinction between constructive discipline and retaliatory punishment—holding that the latter was futile as a means of rehabilitation. This view also emerged from the workgroup on the role of the parents.

The Parents' Role

Changing cultural patterns engrossed a large portion of the attention of the workgroup on parents, particularly in regard to the influence of comic books, television, radio programs, and movies. While the participants agreed that some material provided through the mass-communication media is harmful to child development, they expressed various opinions on the issue of whether the problem could best be attacked by educational methods or by legal censorship.

Noting that parents must be helped to their own fulfillment in order to aid their children, the group commended the growing interest in developing techniques to aid "hard to reach" parents.

Considering the working mother, the group agreed that a mother's employment outside the home may complicate family living but does not necessarily lead to family breakdown. The participants pointed out that work may help some mothers feel more adequate as persons and therefore as mothers. But they also cited Department of Labor studies showing that the majority of women who work do so from economic necessity.

The group delineated several principles for helping parents discharge their responsibilities: (1) citizen participation in planning; (2) efforts to help parents clarify their values; (3) the establishment of specific but flexible goals for children and parents; (4) acceptance and reassurance of parents by professional persons; (5) furthering a sense of parents' personal worth. They deemed a long-term educational emphasis as sound but also saw the need for short-term emergency measures.

Two viewpoints emerged in this group in regard to leadership in parent education. There were those who called for professionally trained leaders, and those who believed that lay leadership under supervision is the only feasible way of getting the job

done. These differences came closer together as the discussion indicated how professional leaders and the less highly trained might mesh their efforts.

This group, too, warned against the search for a panacea, agreeing that no one profession or no single approach to delinquency prevention would be suitable for all communities or for all families within one community; that the parent-education job must involve numerous public and voluntary organizations, sectarian and nonsectarian; and that these must be supplemented by measures to reduce social and environmental pressures on families. Pointing out that gross inadequacies in Aid to Dependent Children programs in many States were forcing mothers to work outside the home, the group adopted a resolution calling attention to the underlying purpose of the ADC program—to preserve family life.

Both the prevention and the parents workgroups stressed the family as the primary source of the child's sense of worth as a person, and family welfare as inextricably tied into community welfare.

The Schools

The workgroup on schools recommended that the school program be broad, flexible, community-focused, and designed to fit the abilities and potentialities of each child and the whole child.

The group suggested that each school develop an inservice training program for teachers and other school personnel as well as a staff-relations organization and that each school system set up a broadly representative school-consultation committee, separate from the board of education, to further mutual understanding between school and community. The group urged that parents be encouraged to visit schools.

The school group also called for curricula geared to individual needs, suggesting special groupings, supervised work-school programs, and, for certain children, residential treatment centers under public-school auspices. It proposed an experimental out-of-doors work camp school for teen-agers, youth-participation programs, and the use of qualified law-enforcement officials in the school curricula to help the students understand law enforcement and their personal responsibilities as citizens.

Urging that the teacher-pupil ratios be reduced to not more than 25 children per teacher, the group recommended long-range planning to anticipate financial needs plus Federal grants-in-aid to the States for specialized personnel. It also called for increased appropriations for the Office of Education of the Department of Health, Education, and Welfare to sponsor workshops, develop pilot projects, further research, strengthen and expand its publishing and information program, and assist teacher-training institutions in developing experimental programs.

Referring to the need for information to identify predictive factors in childhood maladjustments and for exchanging information on programs relating to childhood disorders, the participants recommended continuous accumulative records for each child throughout his school career. Recognizing that the exchange of this information among community agencies involves delicate problems of confidentiality, they suggested that these must be handled differently in various communities, according to the degree of mutual confidence among agencies.

The Police

The workgroup on police services stressed a need for adequate police personnel to handle children who come in conflict with the law and for training police officers to deal with them.

Among the obstacles to proper preventive efforts by the police, the participants noted poor salaries, nonrecognition of the importance of their part in prevention, confusion as to their appropriate responsibilities, and inadequacy of community services for children and youth.

Recreation and casework services under police auspices are not functions of police departments nor compatible with accepted principles of community organization, this group maintained, but it granted that when community resources are inadequate a police department might appropriately call attention to needs and even sponsor an agency to meet them. The group held that the police function does not include casework but includes sufficient social investigation to elicit information basic to an adequate referral or disposition of the case.

The discussion revealed differences in local practices in regard to fingerprinting children picked up by the police, but the group agreed that all fingerprints of juveniles, except those involved in serious crime, should be destroyed along with other recorded material; and that retention be only with the consent of the juvenile court and for a juvenile bureau. The group called for withholding all police and court records of juveniles from the scrutiny of any persons but those actually concerned with the case, except where public interest requires disclosure. It urged

police departments: to study their services to juveniles with an eye to organization and function; to set up carefully considered requirements for juvenile police personnel; and to respect the constitutional rights of the child and his parents at all times. It also requested the Children's Bureau to add a consultant on police services to juveniles to its staff.

Detention

One of the greatest obstacles to effective police work with juveniles, said the police group, is the lack of proper detention facilities. Substantial evidence for this point came out of the workgroup on detention. There it was maintained that 100,000 children aged 7 to 17 years are held in jails and lock-ups each year, awaiting action by the courts, while others are detained in grossly substandard detention facilities; and, that detention would be unnecessary for many of these children if the juvenile courts had adequate probation services and closer coordination with the police, since only children who are a danger to themselves or to the community or who are almost certain to run away need secure custody. The group suggested regional or district detention homes for use by sparsely populated counties and called on the States to help the counties in developing these and upholding good standards of operation.

Among the obstacles to good detention the group cited: confusion as to the responsibility of the State government; failure to recognize need for professional services; insufficient national and State consultation and guidance; insufficient guidance materials; inadequate community services; the perpetuation of vested interests; and political interference. As remedies, the group called for a program of civic education and action. It pointed out, however, that in some instances, especially in regard to regional detention centers, improvement would require changes in State laws.

Juvenile Courts

The workgroup concerned with juvenile-court and probation services gave its major attention to the new Children's Bureau publication, "Standards for Specialized Courts Dealing With Children." Although there was some disagreement among participants over a few details, the publication as a whole was strongly endorsed.

The group enumerated a number of characteristics as essential to effective juvenile-court operation: a properly qualified judge; a staff adequate in size and training; proper detention facilities; protection of records; hearings involving the collaboration of various professions; adequate statistical data; treatment resources to meet the needs of children before the courts.

The group condemned the practice of transferring children from training schools for delinquents to penal institutions for adults, without benefit of judicial process. Calling for the development of more specialized treatment facilities, it suggested that in some instances such resources might be established through interstate action. The participants also held that confidentiality of records should not prevent appropriate information from being given to schools, institutional treatment centers, and social agencies having a legitimate role in working with the individual child. In advocating close cooperative relationships between juvenile courts and the press, the group maintained that the courts had an obligation to protect the privacy of individual offenders by safeguarding them against indiscriminate publicity, but not to put a cloak of secrecy around the total operation of the court.

Institutional Treatment

The workgroup on institutional treatment saw the goal of institutional treatment as a modification of the child's concepts of himself and of his relation to others. The process, said the participants, must be through the establishment of an interpersonal relationship with an understanding adult. Therefore they advocated that the services of social worker,

Each workgroup had four sessions. At the first, a speaker summarized the problems to be dealt with. At the closing session, the group formulated its recommendations. In between, delegates gave problems and solutions a thorough going-over.
—Singer for Dept. of H. E. W.

psychiatrist, and kindred staff be focussed on helping all institution personnel—educational, vocational, religious, and others—to increase their understanding of the youngsters with whom they work and their skills in helping them.

The group held that training schools should not be administered by an agency that has as its primary purpose the administration of programs for adult offenders, but should be related to other services for children. It recommended smaller institutions, with adequate physical plant and personnel, well-planned groupings of children, adequate intake controls, and a relationship between the training schools and the communities and States in which they exist.

Coordination

Nearly every workgroup called attention to the need to coordinate services. The workgroup assigned specifically to the subject defined "coordination" to include efforts to increase effectiveness of services, factfinding, research, joint planning and action, and public information, at various levels of activity. It excluded from the functions of coordination the actual handling of delinquent children or the operation of any direct service.

While advocating that coordinating devices be directed at the total needs of children and youth rather than solely at delinquency, the group recognized that local efforts will necessarily vary in make-up and focus. Nevertheless, it envisaged a model coordinating committee composed of governmental officials, professional staff, and interested lay citizens.

The group called for more public funds for planning and coordination, especially for staff assistance. It warned coordinating bodies against placing goals so high that participants become discouraged. The coordinating process, it pointed out, requires patience and the capacity to let things grow at a rate that permits sound development.

Competition between existing agencies for funds, staff, and status can hinder effective coordination, according to this group, but citizen participation in planning can help to overcome this obstacle.

In considering coordination of services, the group stressed the importance of early discovery of children with behavior problems, diagnosis of their difficulty, and appropriate referral, and recommended the integration and continuity of treatment services, with emphasis on a family-centered program. It advocated case conferences and interagency agreements, followup on specific cases, and the encouragement of outpost services at points where persons in distress appear.

For coordination on the State level, the workgroup advocated interdepartmental committees of official State agencies as well as State commissions or committees on children and youth. While it agreed that advantages are derived from having such commissions appointed by the Governor or established through legislation, it recognized that a number of successful State coordinating and planning bodies have been self-organized.

The group suggested that concern for juvenile delinquency might be lodged in a subcommittee of the State commission on children and youth rather than in a special State coordinating committee on juvenile delinquency. It also suggested that each State place responsibility in an official department or body for providing leadership in the development of research standards and consultation on planning machinery to local groups.

The group also saw a need for coordination and leadership at the national level. It urged the Secretary of Health, Education, and Welfare to form an advisory committee of national agencies, private and public, to be concerned with the provision of technical aid in program operation and planning, dissemination of public information, factfinding and research, and training of personnel.

This group also advocated coordination in neighborhoods and recommended youth participation in the coordinating process.

Training

A number of workgroups—especially those on detention, juvenile courts, police, and prevention—expressed concern about the training of personnel. The workgroup specifically assigned to the problem recognized financial stringency as a major obstacle to more widespread training. While recognizing that support for services could and perhaps should be, in part, financed by the States themselves, it maintained that Federal aid supplementing State or private appropriation is the only hope for real and significant progress in providing what is necessary and especially for any significant development in research and training. The allotment of Federal funds is vitally necessary and consistent with governmental tradition, said the members of this group, since juvenile delinquency is a problem of the people of this Nation.

Accordingly, the group passed a resolution presupposing the establishment of a National Council on

—Hardy for Dept. of H. E. W.

The panels of this display on juvenile delinquency reverse automatically, one side showing the extent and cost of the problem, the other suggesting five steps to improvement. The exhibit is available on loan from the Children's Bureau.

Juvenile Delinquency charged with the implementation of a Federal grants-in-aid program in the field of juvenile delinquency and presupposing that the Secretary of Health, Education, and Welfare would provide professional staff in this connection either within an existing governmental structure or a newly created one. The group saw the projected National Council as having subcommittees on service, training, and research, with funds and staff to operate in each of these areas. It recommended that appropriations include $3,000,000 annually solely for the purposes of training. The group also urged State legislatures to make funds available for the development of staff.

The training group agreed that all casework personnel, regardless of place of employment, needs to understand the problem presented by aggressive youth and the structure and function of the official agencies concerned with them. Referring to a common core of knowledge basic to all personnel in the field of juvenile delinquency, the group advocated inservice training programs and the establishment of training centers, attached to schools of social work or other appropriate agencies, to help persons now on the job who have lacked specialized preparation.

State Legislation

The workgroup concerned specifically with State responsibility held that sound principles of administration and organization must be incorporated in statutes and provision made for full utilization of available facilities and services.

The group agreed that any welfare legislation for delinquents must be drafted in the light of all welfare needs and services for all children, but recognized that varying conditions within the States suggest alternative approaches: (1) the concentration into a single package of all legislation and welfare administration for children, including services to delinquents and predelinquents; (2) a separate legislative and administrative package for services to delinquent children and youth.

The participants noted that drafting legislation requires technical skill; that sound legislation can only be evolved with sound knowledge of existing statutes; that furthering legislation calls for knowledge of the rules and methods of legislative procedure and a sense of timing. Persons supporting legislation, they said, must be clear as to the points on which compromise is preferable to failure and those on which it is not.

Legislative efforts require a different approach in each State and in each situation, the group maintained, pointing out that ordinarily a great deal of groundwork must be laid before specific legislation is achieved. Elaborating, it suggested that representative citizens, key organizations, and individual legislators must be made acquainted with the issues involved and the reasons for advocating specific types of legislation, and their views and reactions solicited; but it added that occasionally an unexpected incident serves as the rallying point for citizen understanding and support.

Research

Many workgroups discussed research needs, on the theory that success in tackling delinquency depends on expanding knowledge, especially stressing the need for research aimed at evaluating current efforts.

The workgroup concerned particularly with research began its deliberations by discussing the problem of basic research *versus* applied research, but as discussion proceeded, dropped the "*versus*" and decided that both types of research are needed. The most pragmatically based study may have important implications for basic theory, and *vice versa*, the group declared, but added that since the "practical" or evaluative study more easily attracts support, it may also be oversold. On the other hand, the group maintained that research into the basic determinants of human behavior must be promoted with complete frankness about its inability to produce quick results.

This group pointed out that juvenile delinquency is essentially a legal concept and not an entity that lends itself to scientific study, and that to be effective in regard to it research must be directed to certain

aspects of human behavior patterns associated with it, such as resistance to authority.

The group also defined needed areas of evaluative research. These included studies of family environment to determine what type of family structure is productive of what kind of behavior; studies of impulse control in normal and disturbed children to determine what causes the differential; studies of the influence of community values on the development of behavior. The group suggested a study of the incidence of antisocial behavior to obtain keener data on how people really do behave, how frequent delinquency is, what normal and deviant behavior actually are.

The group found "shocking" the practice of spending large sums to continue programs while making little or no expenditures to find out what they are achieving. Most agencies, it pointed out, find it hard to obtain funds for studies during their early stages when the research is being designed.

This group passed a resolution calling attention to the need for research personnel and the need for more knowledge about delinquency and asking that Federal funds be made available to States, localities, and universities for the stimulation, support, and extension of significant inquiries into the causation, treatment, and prevention of persistent antisocial behavior in children and adults and for the education of competent research personnel.

Civic Action

All through the conference came the call for civic action and support to achieve the kind of programs that can best combat juvenile delinquency.

The juvenile court group suggested several ways for courts to achieved a constant and continuing program of interpretation to the community. The detention group cited the need for citizen effort to develop a merit system and other protection against political interference, and urged the use of the mass media of communications to promote public understanding. The groups concerned with institutions, with parents and with legislation also called for efforts to further public understanding.

The group especially concerned with civic action held that citizens, while relying on experts to help, must see for themselves what the situation is and what needs to be done. Professional persons must alert communities to their needs, the group maintained, and promote continuing leadership by determining where the central core of each community is. It placed the responsibility for action on localities but recognized that they may need State and National help in highlighting needs, stimulating interest, and providing advice and consultation.

The workgroup emphasized the importance of lay and professional groups working together and using the various channels of communication to dramatize social problems. It also recommended that State conferences on curbing delinquency be organized as early as possible to continue the work of the nationwide conference. Urging that this national conference be considered the beginning of a continuing community-action program, the group called for the development of a national action group, similar in representation to the conference. It suggested that the Children's Bureau carry on the program begun by the Juvenile Delinquency Project, and that the Advertising Council be asked to undertake an intensive educational campaign concerning juvenile delinquency.

Finally, the group noted that the increased number of children, the growing mobility of families, and other changing cultural factors demand a bold approach by the country as a whole to assess needs and determine which most appropriately may be met by local and State groups and which are Federal responsibilities calling for Congressional appropriation. We must and will, the group said, have the courage and wisdom to invest in our children to insure their and the Nation's future.

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[1] Police services for juveniles. Children's Bureau Pub. 344. Washington, D. C.: Government Printing Office. 1954. 91 pp. 35 cents.

[2] Standards for specialized courts dealing with children. Children's Bureau Pub. 346. Washington, D. C.: Government Printing Office. 1954. 99 pp. 35 cents.

[3] Training personnel for work with juvenile delinquents. Children's Bureau Pub. 348. Washington, D. C.: Government Printing Office. 1954. In press.

[4] The Effectiveness of Delinquency Prevention Programs. Children's Bureau Pub. Washington, D. C.: Government Printing Office. 1954. In press.

A BREAK FOR PINBOYS

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RECENT COORDINATION OF EFFORT on the part of national organizations which have become aware of the dangerous and unhealthy aspects of the pinboy's job promises to reach into the bowling alleys of the Nation to protect children and youth. Led by the Advisory Committee on Young Workers, of the Bureau of Labor Standards, U. S. Department of Labor, the concern of these groups crystallized sufficiently at a conference last February for a program to be ready for the current bowling season. Most significant element, perhaps, is the inclusion of leaders in the bowling industry itself. But its success will be measured by the degree of awareness it arouses in States and local communities among those concerned with children's health and welfare, of conditions under which pinsetters work, of the place of bowling-alley regulation in the overall program of child protection and of the vigilance required if good standards are to to be observed.

By 1940, 45 States had some child-labor regulation of bowling-alley employment. In recognition of the factors that make this type of job unsuitable for young boys, 24 of these States had set a higher minimum age for pinsetters than for most other employment. But labor shortages during the war led to attacks on these standards in many areas. The 5 States that had a minimum age of 18 for pinsetting were pressed into reducing this minimum to 16 or lower. Then bowling alley proprietors found that they could not get enough 16-year-olds to man the alleys, either. The job was so hard, the hours of work so undesirable, and conditions so bad, that boys of legal age for factory employment shunned pinsetting as work "for kids who don't know any better." Attacks were then made on the 16-year minimum age laws and the nightwork prohibitions which in many States would have kept boys under 16 from being used in the alleys during the busy evening.

The results were that after the war, although slight gains had been made in 3 States, child-labor regulations in bowling alleys had generally been greatly weakened. Six States had a *lower* minimum age for pinsetting than for other employment. Eleven States had no minimum age for outside school hours employment of pinsetters, 5 of these having no nightwork prohibition either, thus permitting boys of any age to work all night. One State had reduced its 16-year minimum age to 12. Six States had dropped the 16-year minimum to 14, and night-

—*Photo From McCall's Magazine*

work restrictions were widely relaxed or ignored. Wartime relaxation of most other labor laws had been temporary and were removed after the war. But it seemed impossible in most States to get back to the child-labor regulations for bowling alleys which they had had, and which were necessary to protect the health and welfare of boys. Eventually the Korean conflict again tightened the labor market and very young boys continued to set pins into the late night hours in most parts of the country.

Complaints and requests for help came in increasing numbers to the U. S. Department of Labor from school officials, health and welfare workers, officials in State departments of labor, and many other organizations and individuals concerned about the wholesome development of boys. Therefore, the Department's Bureau of Labor Standards decided to make a survey of conditions and to get the opinions and suggestions of those close to the problem in a number of communities.

Working Conditions

From this survey emerged a picture of the job of pinsetting and of its effect on the boys. It found that since bowling alleys are busiest in the evening, pinsetting nearly always involves nightwork, usually until 11:30 p. m., often later. School-attendance workers complained that truancy resulted because boys were too tired to get up for school or had suffered injuries on their jobs in the alleys. Teachers told of boys falling asleep in class because they were worn out from the late hours and hard work. One school superintendent told of a 10-year-old boy who set pins from 4 to 10 p. m. 4 nights a week and of four others, all under 14, who worked from 4 p. m. to midnight 7 days a week. The irregularity of attendance that resulted from such employment caused school failures and early dropouts. School health workers reported that the boys were often missing their meals and living on candy bars and cokes bought at the alleys where they worked. School officials in general reported a correlation between poor health, poor attendance, poor scholastic achievement, and work in bowling alleys.

Pinsetting is extremely hard work, too, particularly when the boy serves two alleys. The ball used in tenpins weighs 16 pounds. Each player rolls the ball about 50 times during the course of the three games bowled by each league. Since there are usually five men on each team, the boy must pick up and return the 16-pound ball 500 times during the 2 hours of league play. Stooping to pick up and return the ball, picking up and setting the pins, leaping over the partition to do the same for the competing player in the next alley requires not only great speed but much energy as well. When boys work from 4 p. m. to midnight on this job, they can hardly avoid exhaustion.

Pinboys are also exposed to considerable accident hazard. Typical injuries which are mentioned frequently in the records of State labor departments are broken or mashed fingers, broken noses, concussions, split lips and loss of teeth, lacerations on various parts of the body, leg fractures and bone injuries caused when boys are hit by balls and flying pins. One State reported 135 pinsetters among the workmen's compensation cases closed the preceding year. Seventy of these had some degree of permanent partial impairment and 9 others were compensated for serious and permanent disfigurement. The remaining 56 cases involved temporary disability of over 6 days' duration. One 13-year-old boy in New England was hit on the ankle by a ball. Osteomyelitis resulted which kept the boy in and out of hospitals for years and, although several operations were performed, the boy was permanently disabled. Total compensation paid was $10,798 plus $2,332 for medical expenses.

Many accidents to pinboys are not reported, sometimes because there is no coverage under the State workmen's compensation laws, but often because the employer does not recognize his responsibilities for reporting. Sometimes accidents come to light only when the youngster is absent from school or when the injury is so serious that the parents seek help.

Employment Practices

Other adverse conditions which cause many people to regard pinsetting as a bad job for any boy arise from poor employment practices. Many proprietors do not seem to think of themselves as employers or regard the pinsetter as their employee. Boys come in off the street, are put into the pits to work, and are paid off when the rush is over. Neither the boy nor his parents know when, or how long, or where, or if, he is going to work when he starts out to make the round of the alleys, looking for a chance to pick up some change. In some cases the boys were missing from their homes for several days, sleeping on cots or rags in the alleys, because they worked so late they were afraid to go home. This practice is especially serious where adult "drifters" work and sleep in the alleys along with the boys.

Recordkeeping is neglected in many alleys. Often

the proprietor does not know the boy's full name or his address, or whom to notify if an accident occurs. Many of the boys do not have employment certificates even in States where these are required.

A pinboy gets little training, usually only what he picks up from observation while hanging around the alleys. Supervision is inadequate, because the proprietor, concerned primarily with the bowlers' end of the alley, is apt to pay little attention to the pits except to speed up the boys or to get underage boys out of the way when a labor inspector is rumored to be approaching. School officials say that one of the industry's worst evils is the disregard for law engendered in boys who are taught to lie about their ages or sneak out of the alleys.

The adult companionship to which the pinboy is often exposed on his job is another detrimental feature. Bowling alleys are chronically short of pinsetters, and derelicts or drunks from the cities' "skid rows" know they can pick up quick money by setting pins. Often they bring their liquor into the pits with them. The pastimes behind the scenes while boys wait for bowling to begin may include gambling, cards, and all sorts of horseplay. In this setting some boys conceive and plan antisocial activities which they carry out on their way home. In some communities gangs of pinboys leaving the alleys late at night have been involved in looting cars and other acts of vandalism.

Even in States with laws prohibiting employment of boys under 16 late at night widespread violations were reported. State enforcement officials reported that their staffs were too small to get around to all the alleys during the night hours. They said that judges often seemed to be more sympathetic to the manpower needs of the proprietors than to the plight of the boys. When open and determined defiance of the law exists, enforcement is almost impossible.

When the Bureau of Labor Standards presented its report,[1] *The Boy Behind the Pins*, to its Advisory Committee on Young Workers, the committee suggested that representatives from the Bureau and the committee approach leaders of the bowling industry and bowling leagues to dicuss the findings and to enlist their understanding and cooperation in support of law observance and improved employment practices. The committee also recommended that the Bureau call together representatives of national organizations concerned with youth in order to create an awareness of the situation and to stimulate moves for improvement in the many communities represented in their membership.

Discussions with representatives of proprietors' associations and bowling congresses showed that these organizations realize that improved conditions would raise the status of bowling and help bowling-alley proprietors by improving their community relations, reducing turnover among pinsetters, and making it easier to recruit an adequate supply of pinsetters. It became clear that proprietors could do much to make the job suitable for and acceptable to older boys. The proprietors' representatives agreed to explore the possibility of drawing up a code of good employment practices which its representatives felt their membership would accept.

Plans for Improvement

Representatives of national organizations concerned with youth and of the proprietors' associations and bowling leagues met in February at the invitation of the U. S. Department of Labor to develop a program for improving conditions for pinboys. The National Child Labor Committee contributed information from a survey of pinboys which it had conducted,[2] the League to Promote School Attendance reported on its poll of school-attendance officers' opinion,[3] and representatives of State departments of labor and others told about conditions in their areas and measures that had been, or might be, tried.

At this meeting representatives of the Bowling Proprietors Association of America reported on proprietors' difficulties in securing an adequate labor supply. They expressed a desire to remedy bad conditions where they exist, but maintained that these are not typical of all bowling alleys. However, they pointed out that their efforts would be handicapped by the newness of their association and the fact that not all proprietors belonged to it. As proof of their good intentions they presented their suggested code, *My Pinsetters and I, a Guide to Good Practice*,[4] which if followed would do much to make the job better for properly selected boys. In this code the proprietors undertake to: observe their State and local laws regarding pinsetter employment; provide healthy and safe working conditions; supervise the conduct of boys in their employ and protect them from undesirable influences; cooperate with parents and school authorities in regard to working hours and employment arrangements for boys.

Since the conference the national organizations of proprietors and bowlers have circulated the code to over 6,000 bowling-alley proprietors urging that

they post it and live up to its responsibilities. They are also getting it to the bowlers through their bowling leagues and bowling journals.

The citizen organizations represented at the conference are supporting the program of the proprietors and bowling organizations by publicizing the code in their journals and in program letters to local affiliates urging that they bowl in alleys where the code is posted and observed. They recognize, however, that there is still much to be done by citizen groups. Some States still have no legal minimum age for employment in bowling alleys, some have a substandard minimum. There are sometimes pressures to break down the 16-year minimum age in States that have achieved that standard. At the conference these organizations agreed to work for good laws and law enforcement and to prevent breakdowns in child-labor laws in States where there is now a legal 16-year minimum age.

Community Action

Pinsetting as practiced in many bowling alleys today involves both the health and welfare of children and youth, and is therefore a proper concern for all those charged with the well-being of children. Community workers who come in contact with boys whose problems stem in part from their work in bowling alleys can bring this fact to the attention of their professional and lay associates. They can work with other groups in carrying out some of the suggestions for community action set forth in *The Boy Behind the Pins* and *Up Your Alley*. With firsthand understanding of the problem they can help bowlers see the importance of refusing to take their recreation at the expense of the boys in the pits, and can help parents and young boys understand why pinsetting is not a good job for young people.

The national campaign to improve conditions for the half million pinsetters employed during the course of a year, launched so auspiciously last February, cannot succeed unless interested groups in every community support it. Local improvement in conditions will come through the action of individuals and community-wide cooperation. Many communities and organizations need to join in Statewide moves to get and keep good legal standards.

Such action can be effective. Last spring two bills to break down the child-labor law in Massachusetts and one in Louisiana were defeated because enough informed and concerned citizens made their influence felt. In one Iowa community women bowlers who became aware of the problem through their national organization refused to bowl in an alley where underage pinsetters were employed. This is the kind of language every proprietor understands. When individual proprietors in each community see that the public really cares what happens to the boys who work in their establishments, improvements will be made.

Who takes the lead in stimulating community concern will vary from place to place. It may be a council of social agencies in one community, an attendance officer or health official in another, or a youth council in a third. Everyone can work together to see that action on behalf of pinboys results from all this information and concern. The bowling season is on. If action has not started in your community, pick up the ball and get it rolling.

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[1] The Boy Behind the Pins. U. S. Department of Labor, Bureau of Labor Standards, Washington. Bull. 170. 1953. 48 pp. For sale at 25 cents by Superintendent of Documents, Government Printing Office. Single copies available without charge from the Bureau of Labor Standards, Washington 25, D. C.

[2] Alway, Lazelle: Up your alley. National Child Labor Committee, 419 4th Avenue, New York 18, N. Y. Pub. 410. 1953. 31 pp. Single copies free. Write for quantity rates.

[3] The other end of the alley; a report presented at the Conference on Improving Conditions for Pinsetters, by John A. Cummings, President, National League to Promote School Attendance. 1954. 4 pp. Single copies available without charge from the Bureau of Labor Standards, U. S. Department of Labor, Washington 25, D. C.

[4] My pinsetters and I; a guide to good practice. Recommended by the Bowling Proprietors Association of America. 1954. 1 p. Single copies available without charge from the Bureau of Labor Standards, U. S. Department of Labor, Washington 25, D. C.

To me the worst vandals are not children but the adults who wreck the character of children and destroy the lives of children by their attitudes. Children are the most beautiful things I know of.—Lawson G. Lowrey, M. D., former director, Institute of Child Guidance, New York.

What the United Nations and UN affiliated agencies are accomplishing in their . . .

INTERNATIONAL ACTION FOR CHILDREN

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UNDER ITS CHARTER, the United Nations and its affiliated agencies have a mandate to seek "higher standards of living" and "conditions of economic and social progress and development" for *all* of the 2½ billions of people living on this planet. Even if we limited our activities entirely to the underdeveloped areas of Asia, the Middle East, Africa, and Latin America, we would be dealing with about 1¾ billion people, 80 percent of whom live in villages and rural areas.

Even in the advanced countries rural areas are the last to share in public health and welfare services. The United Nations preliminary report on the *World Social Situation*[1] concluded that the peasants of the underdeveloped areas have been the forgotten men of the 20th century and have benefited less from its changes than any other group. Our best estimates indicate that half of the people in the world are still living at levels which deny them a reasonable freedom from preventable disease; a diet adequate to physical well-being; a dwelling that meets basic human needs; the education necessary for improvement and development; and conditions of work that are technically efficient, economically rewarding, and socially satisfactory.

Against the vastness of these needs are the facts that the United Nations and most of its specialized agencies are less than 10 years old and have total resources of less than $25 million per year for assisting governments in the health, nutrition, education, labor, and welfare fields, if we exclude the emergency-relief programs in Korea and the Near East.

Should we then despair and consider that the language of the Charter is simply "pie in the sky"? While we are not the incurable optimists who believe that progress is inevitable, most of the representatives and officials of the United Nations still believe that our goals *are* attainable if we harness man's vast spiritual and physical resources to our common objectives. The United Nations, after all, is not working *against* the stream of history but is a reflection of the fact that fatalistic resignation to poverty and disease is giving way to the demand for a better life. Every government is now wrestling according to its abilities with the problem of its population's standard of living. The UN's job is to foster mutual aid, to find the common denominators in successful national experience, to stimulate both governmental and nongovernmental agencies to the utmost outlay of creative energy to raise the general welfare.

International Social Program

What is it that the United Nations adds to the efforts of national governments, of voluntary societies, of self-help efforts of the people themselves in raising their standard of living and achieving social progress and development?

To begin with, the UN Department of Social Affairs has added to the systematic knowledge of social problems and to the analyses of the background data necessary to economic and social planning. Through its statistical and demographic offices it has worked extremely hard and with considerable success in improving the quality and scope of the midcentury censuses. For the first time,

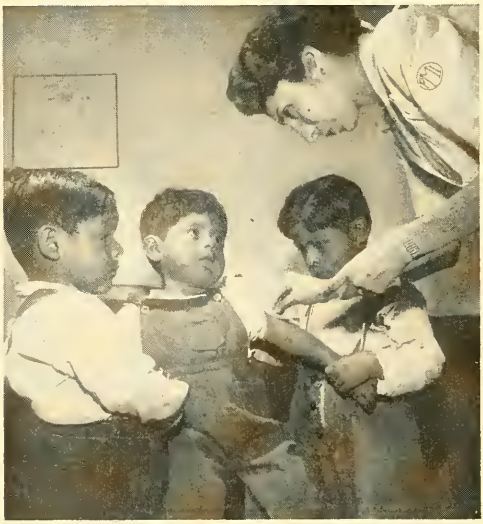
Based on a paper given at the 1954 forum of the National Conference of Social Work.

many underdeveloped countries have at their disposal an intelligible array of facts concerning the characteristics of their own population—they know how many children they have, how many aged, something more of their birth and death rates, occupational structure, income levels, housing conditions, educational levels.

The importance of these data for social planning cannot be overestimated. The Population Division has analyzed population trends and pointed out the relationship of the facts and the projections to economic and social development.[2] The Division of Social Welfare has analyzed many national social programs on a comparative basis—for example, measures to strengthen family life[3]—as a background for social policies to be recommended to governments. The Division of Social Welfare has prepared the comprehensive reports, the *World Economic Situation* and the *World Social Situation*, to serve as guideposts for both national and international action.

I cannot enumerate here, of course, the growing wealth of technical studies in every field of social endeavor which the international agencies have prepared at the request of their member States; suffice it to say that anyone in the health or welfare fields would be forced to be highly selective in choosing the documentation most helpful to his community or agency in improving health, education, labor, or welfare services.

In Peru, where in certain areas inoculation against typhoid is necessary, two "big" boys help their little brother prepare for his shot. The mass protective project is part of a public health program aided by the World Health Organization.
—*WHO Photo*



Combined Efforts

Not a few of these studies represent the combined efforts of the United Nations, one or more of the specialized agencies and the nongovernmental organizations. For example, the Division of Social Welfare undertook a study of the adoption of children in 13 countries around the world with the active cooperation of the International Union for Child Welfare,[4] the Secretariat undertaking the legislative aspects of the study and the Union making the major contribution on adoption practices with the help of national committees. As a companion study, WHO, with the collaboration of UN, called an expert committee composed of psychiatrists, psychologists, pediatricians, and social workers on the mental-health aspects of adoption.[5]

The necessity for governmental cooperation in furnishing data for these technical studies highlights at the same time a major strength and a major weakness in United Nations work. On the positive side, governments find that they must analyze themselves in order to answer the questionnaires of international agencies. While officials grumble about the work involved, they confess privately that it forces them to think about their social problems, to coordinate the efforts of many ministries and even at times to find new methods of National, Provincial, and local cooperation. On the negative side, the UN's very dependence on governmental sources of information sometimes keeps it from uncovering the real facts or at least restricts its freedom to publish facts to which it has no official access.

In addition to this social research, which has great importance as the tool of policy formulation, the United Nations and the specialized agencies in the social field have undertaken considerable practical fieldwork. This falls into two broad categories: direct assistance to special groups such as refugees and displaced persons; and technical assistance to governments in the social field.

There is the work in Korea. In the shadow of an uncertain future for that devastated land the United Nations Korean Reconstruction Agency is carrying on health and feeding programs, agricultural reconstruction, education, rehabilitation of the handicapped, care for homeless children, and perhaps most

—*United Nations*

Pupils at one of the rural schools in Sitio del Nino, El Salvador which has adopted curriculum proposed by UNESCO.

encouraging of all, community development projects. In close cooperation with the United Nations Civil Assistance Command UNKRA must bind up the wounds of this land.

There is also the frustrating history of aid to 800 thousand Palestinian refugees who are the victims of the birth of a new nation in the Middle East. They are still UN wards in their crumbling mud shacks and tents, with their meager wheat and milk ration, awaiting the political settlement which will allow some or all of them to return to their homeland or find new homes in the Arab States. A few thousands are now working on economic deveopment projects supported by the United Nations Relief and Works Agency and the host governments, but the great majority must spend their days in unproductive activity and in bitter contemplation of their fate. The youngsters are in classes established by the United Nations Education, Science, and Cultural Organization, and health and welfare services are provided for the whole of the refugee population.

The bridge between the supply and emergency relief programs on the one hand and technical assistance activities of UN and the specialized agencies is United Nations Children's Fund, known as UNICEF. This Fund was put on a continuing basis by the General Assembly in 1953 and the words "emergency" and "international" stricken from its title. This has not detracted one iota from the sense of urgency felt by the members of UNICEF's Executive Board, for as the delegate from Israel said: "The needs of children are always an emergency."

The primary emphasis of the Fund continues to be on mass health programs. With the cooperation of the World Health Organization and the participating governments, which more than match every cent of UNICEF aid, 50 million children have been tested for TB and 22 million vaccinated with BCG antituberculosis serum. Mass-feeding programs have served another 11½ million mothers and children. Since 1950, however, the nature of the UNICEF programs has shifted to long-range activities. Health and nutrition programs, milk conservation in the form of pasteurization and drying plants, and partial support in supplies and equipment for 5,300 maternal and child health and wefare centers are included in the impressive score of UNICEF activities to the middle of 1953.[6]

The story of the joint action of UNICEF, WHO, the UN Department of Social Affairs, and the Food and Agriculture Organization was told to the 18th session of the Economic and Social Council last July. Examples were the successful collaboration of the four agencies in providing a new soybean-milk production unit in Indonesia and protein-rich fish flour for children in Chile. In both cases, FAO and WHO cooperated in finding local foods which would meet the protein needs of children and in

A survey team of a government nutrition program in Thailand, aided by FAO experts, examines a rural family's food supply.

—*FAO Photo*

carrying out acceptability tests before UNICEF helped the governments by providing engineers and equipment for producing these foods. Regional social welfare advisers have participated in nutrition conferences both in Indonesia and Latin America to ensure that feeding programs of UNICEF and FAO are carried out in a manner that will bring lasting rather than short-term benefits to mothers and children. Another example of joint action is represented by the Maternal and Child Welfare Center in Bangkok, Thailand, one of the many established with UNICEF and WHO assistance. A UN social-welfare worker included in the team has successfully organized a local advisory committee for the Center to provide it with roots which may be expected to preserve it after international assistance is withdrawn.

Technical Assistance

The Technical Working Group on Long-Range Activities for Children, which is composed of specialists from the UN Division of Social Welfare, UNICEF, WHO, FAO, UNESCO, and ILO, meets regularly to work out joint policies and programs at the Secretariat level so that proposals to the governing bodies of all the agencies may be in harmony. One important joint action decided upon at its 1951 meeting was the program to assist governments in assessing the needs of children in their country and examining all their services for meeting those needs. Such assistance has been given to Burma, El Salvador, and Syria in the past 12 months by the joint efforts of the agencies concerned. Self-examination of this kind by any government inevitably reveals the gaps in services, the need for better coordination, and it offers a sound basis for international help.

The technical-assistance activities of the United Nations in the social field are hardly less dramatic and their practical impact in relation to the dollars invested is most encouraging. An increasing amount of our staff time, supplemented by nearly 750 experts yearly and nearly 750 fellowships to applicants from the underdeveloped areas [7] goes into these long-range activities to assist governments in initiating or improving health and social services.

For example, take the work of WHO in the control of malaria. During the year 1953, WHO assisted 21 countries in malaria control, in many cases in cooperation with UNICEF. The director-general of WHO and the executive director of UNICEF have both reported that 1953 may well prove to have been the turning point in the history of malaria control. Many of the countries of South East Asia and the Middle East are attacking malaria as a national health problem. WHO has offered training of many kinds to meet the increasing demands for assistance in strengthening national malaria-control organizations, and each team has provided systematic practical training in malaria projects. It has also given assistance to malaria institutes and centers for training in insect control.

Health authorities and, to a growing extent, economic ministries have long recognized that the malaria scourge was a major obstacle to economic development, costing the nations, in tropical areas in particular, millions of man-months of labor every year. The people themselves in many countries have demonstrated their enthusiasm for the kind of help which they are receiving from the international or-

ANOPHELES ON THE RUN

Only a few years back the malaria-carrying anopheles mosquito was designated as world health enemy Number One by the World Health Assembly. Now it looks as though this indivious insect's days may be numbered, as an increasing number of governments level concerted attacks against it. In these efforts they are aided and abetted not only by the United Nations specialized agencies as described in the accompanying article but also by the Foreign Operations Administration of the United States.

Of the nearly 400 United States technicians working in 38 nations overseas in FOA technical-cooperation programs in the health field, many are engaged in malaria-control programs in the Near East, South Asia, Africa, Far East, and South America. FOA, for example, supplied equipment and training for teams that DDT-sprayed 80,000 houses per month in North Vietnam, Indochina, a total of 220,000 houses in the Philippines, and 13,000 villages in Iran, and contributed to amazingly successful anti-malaria programs in Venezuela and Brazil. In India, where malaria causes 1,000,000 deaths a year, FOA has furnished $5 million worth of DDT equipment which will be used to spray 125 million houses.

ganizations. In Afghanistan, for example, the people of a remote section in the North petitioned their Government to maintain the WHO malaria-control team in their area.

Malaria control is only one aspect, of course, of the important work being done in the health field. There are also effective efforts in regard to maternal and child welfare, such as the centers already mentioned. In addition, recognizing that spectacular gains in the health field must be established on the bulwark of strong public-health organizations, WHO has concentrated a sizable portion of its resources on the strengthening of national health services. It has worked not only in the national capitals, but also in outlying areas where teams of experts have demonstrated the effectiveness of coordinated public-health, nutrition, education, and welfare services.

Aid to Education

This kind of effort in the health field is closely paralleled in the fundamental education program of UNESCO. This agency has recently given an increasing amount of attention to primary schooling for children and fundamental education for adults and children who have not had the advantage of formal schooling. Thus it attempts to reach the illiterate with the simple facts about their environment, their health and welfare, and the means of increasing their agricultural production. This type of instruction is in many countries combined with special literacy campaigns.

Two regional fundamental-education centers established by UNESCO in Patzcuarro, Mexico, and Sirs-el-Laiyana, Egypt, draw teams of young men and women from the 20 Latin American countries and the 6 Arab States for training as fundamental education teachers. On their return home these trainees establish similar centers in their own countries for training teachers and community leaders. Thus UNESCO is contributing to the total effort in community development being made by UN and the specialized agencies.

In the labor field, the International Labour Organization has stepped up its work in vocational training as a direct contribution to economic development. At the same time it has pursued its long-term efforts to see that any improvements in productivity go hand in hand with advances in social policy leading to better conditions for the workers and better food, clothing, housing, and other necessities. To achieve these ends, the ILO has worked closely with governments on legislation concerning hours of work, holidays, safety, and other labor standards. At the same time the agency has fostered the cooperative movement, particularly in countries of South East Asia, where the cooperatives are making an important contribution to the development of their economy. The ILO also makes advice available in the fields of vocational guidance, employment-services organization and the protection of women and young workers, thus helping the underdeveloped countries to avoid much of the stress and personal and social injustice which accompanied the industrial revolution in the West.

The FAO is also making a contribution in the social field, particularly through its nutrition and home-economics programs. It has established special institutes for the study of local foods and local diets in a few areas. One of the most successful is the Nutrition Institute in Turrialba, Costa Rica. This work is particularly important if the efforts of UNICEF are to have a long-range effect, for, since the countries cannot indefinitely feed their hungry children on imported milk, new local sources of proteins, fats, and minerals must be found.

One of the more important projects of the FAO has been its cooperative effort with WHO in an attempt to stamp out kwashiorkor, a disease of protein deficiency. As a result of powdered milk furnished by UNICEF, the effects of this widespread disease among African children have already been mitigated. The FAO, however, is going at the roots of this problem by encouraging the production and use of native protein foods.

FAO is also giving considerable attention to the home-economics side of agricultural extension systems upon which it is advising many of the countries in underdeveloped areas. UN's findings in regard to family and child-welfare services indicate that the management of the household and preparation of food can make almost as important a difference in the standard of living in many countries as any actual increase in food production.

Social Welfare

Space limitations prevent me from giving more than the highlights of the activities of the UN Division of Social Welfare.

The broadest opportunity for assisting a government in an advisory capacity came in a request from Burma for UN help in preparing a new and comprehensive program of social services. Burma, which had previously accepted assistance from the United

—*United Nations*

Two students at the Demonstration Center for the Rehabilitation of the Blind in Cairo, Egypt. Established with the cooperation of the United Nations Technical Assistance Administration, the center trains Braille printers and teachers of the blind, prints textbooks and teaches crafts to blind people.

States in the preparation of its economic development plans, was eager to have a parallel plan for the distribution of the accruing economic benefits to the most needy parts of its population. Accordingly, UN sent a team to Burma, headed by its regional social-welfare adviser, and including experts in labor welfare, family and child welfare, community organization, primary education, and health services. The team's report has already been accepted by the Government of Burma and UN advisers are now helping to carry out its recommendations.

Similarly, UN has seized the opportunity of assisting two other Governments, Syria and El Salvador, in a survey of their services for children. A series of concrete recommendations to help those governments fill the gaps in their programs and improve the organization and training of their child-welfare staffs have resulted.

UN is stepping up its activities in training both professional and "community" social-service workers. In the past 7 years it has sent missions to 18 countries to establish or improve professional schools of social work. In recent years the Division of Social Welfare has been particularly conscious of the need to extend the interest of the professional schools to the training of auxiliary and community workers. In light of the pleas made in the Social Commission by representatives of underdeveloped countries, the Division has urged that the professional social workers themselves undertake the responsibility for training aids who must carry out all the work in the villages, emphasizing that such workers be considered as supplements to professional social workers and not as substitutes for them. In a cycle of three meetings on the best methods for training auxiliary and community workers held in Gandi Gram in India, Beirut in Lebanon, and Bogota in Colombia, UN experts have searched out the persons who are actually running village institutes and training courses for community workers and have explored with them the reasons for success or failures. The Division is now discussing the results of these meetings with the specialized agencies in the hope of undertaking some joint demonstration training courses in 1955.

The international program for rehabilitation of the handicapped has captured the imagination of many social and health leaders interested in the work of the United Nations. Again, this is a field requiring the combination of the social welfare interests of the UN with the health, education, and labor interests of its affiliated agencies. Un has worked with these agencies as a team to establish demonstration centers in Yugoslavia and Egypt and will soon establish similar centers in Brazil and in India. The nongovernmental organizations have cooperated splendidly in these efforts. Currently UN is exploring the possibilities of establishing a new demonstration center in Turkey with the help of the World Veterans Federation, because of UN's moral responsibility for the handicapped Turkish veterans of the Korean war.

The Division of Social Welfare is also giving major attention to the prevention and treatment of juvenile delinquency. Following discussions at meetings of experts in several countries the Division has granted a number of fellowships and scholarships to social workers and administrators dealing with these problems in the underdeveloped countries. In a few cases advisers have been sent to the countries. The countries most interested in this problem in our Councils and Commissions are the countries now undergoing a rapid economic development—a reflection of the fact that the rate of juvenile delinquency seems to increase with the rate of urbanization and industrialization.

An important phase of UN's work in the social field is its program for the extension of low-cost housing. UN has recently collaborated with the Government of India in a large-scale exhibit of stabilized earth construction. More than 1,000 houses and a complete community center were built as a model,

each house constructed for less than $1,200. Since thousands of people per day visited the exhibit the project promises to have a real impact throughout South East Asia. The exhibit terminated with a seminar which made a number of specific recommendations to governments in that area concerning public housing programs, use of local building materials, and the use of self-help techniques for rebuilding the villages. The relationship of this program to the community-development program is becoming more clear each year as we send out experts in this field.

There is scarcely an important social program on which UN is working which does not require the joint action of the health, labor, education, and welfare agencies on an international as well as on a national level. This is particularly demonstrated in the community development program, in the training programs, and in our efforts to strengthen our administration of social services in the underdeveloped areas. The Economic and Social Council has directed that special attention and concentration be given these areas for the next few years.

The Results

What has been the impact of this development of international social policies, of this volume of technical assistance, and the limited amount of direct aid in special areas?

In the health field, the results are impressive. Malaria has been greatly reduced. It is estimated that the incidence of tuberculosis among children in the areas in which WHO and UNICEF activities have been concentrated will decrease by 80 percent as the result of the injection of 36,000,000 children with BCG.

In education, UNESCO activities harnessed with the governments of the underdeveloped areas have increased notably the number of children in school, lessened discrimination against girls, and turned the emphasis in primary education on fitting children to live in their environment. The problems of teacher training, basic training materials, and school buildings are still tremendous obstacles to the advances which countries are psychologically ready to accept.

Against poverty, our progress is least impressive, The age-old problems of wornout land, low productivity of labor, poor organization of the labor market, poor distribution of industrial plant and "know-how" are not problems to be solved with the wave of a wand or a magic drug. Here international efforts most need to be combined with the bilateral programs of economic aid and technical assistance and national moves to increase industrial and agricultural productivity and international trade. UN and its affiliated agencies are making a contribution on the social side of these efforts by helping countries to anticipate the problems of dislocated families, urbanization, delinquency, and special needs of children, and to help them organize their welfare services to avoid many of the mistakes made by the Western world in the period of its industrial revolution.

The UN is doing its utmost to improve the quality and geographic spread of its program, to coordinate the efforts of the United Nations family of organizations, and to interpret the program in a way which will command public support and the full cooperation of nongovernmental organizations.

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[1] UN Publications Sales No. 1952. IV. II. Document E/CN.5/267/Rev. 1.

[2] Determinants and Consequences of Population Trends (Document ST/SOA/Ser. A/17—Sales No. 1953. XIII.3).

[3] Economic Measures in Favor of the Family (Document ST/SOA/S—Sales No.: 1952.IV.6).

[4] UN SOA "Study on Adoption of Children" (ST/SOA/17).

[5] Technical Report Series (WHO) No. 70.

[6] UNICEF—The Compendium—Vol. IV—1953–54.

[7] 6th Report of the Technical Assistance Board to the Technical Assistance Committee. (Will be available for distribution to the public in June 1954.)

Our crisis is a crisis in values, in the things men live by and for. . . . It can be resolved for the better only through a change in the quality of human relations beginning in the family and school and reaching out to the ends of the world.—Robert J. Havighurst, Ph. D., University of Chicago.

PROJECTS AND PROGRESS

Prematurity and Congenital Malformations

Findings about congenital malformations, resulting from research studies in Europe and the United States, recently received the careful attention of scientists from both sides of the Atlantic. The occasion was the second conference on Prematurity, Congenital Malformations and Birth Injuries, sponsored by the Association for the Aid of Crippled Children and held in New York, June 15–16. Nearly 50 scientists from the United States, England, Scotland, Wales, Ireland, Norway, Sweden, and Finland attended. Their attention was focused on: sociological-clinical problems, especially the effects of external environment on the fetus; the placental barrier; and the fetus in relation to energy stores, internal milieus, and respiration.

In order to further a free flow and exchange of ideas, the conference had been patterned along the lines of informal discussion, with few set papers prepared or delivered. A rich store of knowledge emerged from which it is possible in this space to record only a few highlights. The full proceedings will, however, be published in a forthcoming book now being prepared from tape and stenotyped recordings.

Dr. Theodore Ingalls reviewed some of the findings of his research into congenital malformations and immaturity sponsored by the Association for the Aid of Crippled Children at the Harvard School of Public Health. He believes that these studies show: (1) that there is no single cause of a given malformation, but any one of several causes may result in the same malformation; (2) that most anomalies develop *in utero* as a result of multiple interacting factors; (3) that some of these (largely genetic) cannot be controlled to any great extent, but that others such as infections and nutritional imbalances may be susceptible to control by concerted research, and by clinical, medical, and public-health measures; (4) that the causes of deformities and of intrauterine deaths are closely related and hence efforts calculated to affect either may influence the other; (5) that considerable evidence exists to indicate that the type of defect is determined more by the host (mother) than by the injurious agent; (6) that according to animal experimentation, anoxia (lack of oxygen) at various stages of pregnancy, particularly in the first trimester, is one of these injurious agents.

Dr. James Walker, of the University of Aberdeen, Scotland, reported on studies made over a 15-year period by Dr. Dugald Baird at Maternity Hospital, where 95 percent of all first pregnancies in the city of Aberdeen receive care. Dr. Baird's findings hold significance for social workers and public-health personnel as well as pediatricians and obstetricians everywhere for they reveal that the babies of women in Aberdeen's highest economic class showed the lowest stillbirth rate and the lowest rate of infant death during the first week of life. The infant death rate in this group was 24 per 100,000 as compared with 44.6 per 100,000 for women in the lower economic groups.

The same study showed that deaths due to fetal deformity were 1.4 per 1,000 in the upper economic bracket and 10.9 per 1,000 in the lower; while deaths due to prematurity were 5.6 per 1,000 in the upper and 13.9 in the lower brackets.

Dr. Walker listed the five social groups which were used as a basis for the study: professional and other well-to-do people; intermediate; skilled workers; semi-skilled; unskilled. While many changes have rendered the economic differences between these classes much less clear since World War II, Dr. Walker believes they still represent different standards of living which are reflected in standards of health and physique.

Drs. Walker and Baird have produced evidence to substantiate a view long held by many observers in this and other countries: that the efficiency of reproduction and the vitality of children produced by any group of women is largely determined by their state of health and physique and that this in turn depends to a large extent on the social conditions in which they were brought up from birth.

Their studies reveal further that tall women (5 ft. 4 in. or more) have a lower infant mortality loss than short women (5 ft. 1 in. or under). This is apparently true because, in Aberdeen at least, taller women come from higher economic levels and have better pelvic bone development. Tall women in Aberdeen produced an infant mortality rate of 29.4 per 1,000 compared with 47.1 for short women.

While the extremes of malnutrition are rare in Aberdeen, the highest incidence of prematurity, and of infant deaths due to unexplained prematurity and deformity, clearly occurs in the lowest economic groups. In these groups the women have as high a standard of medical care as those in other groups. Dr. Walker pointed out that once economic class is taken into account, diet, paid employment during pregnancy, and housing seem to have no influence whatsoever in the results.

Discussing the role of the obstetrician in preventing stillbirths, Dr. Walker said: "It seemed clear that skilled antenatal care, good care during labor and pediatric care of an equally high standard can help to save many infants who would otherwise die or suffer permanent damage . . . However . . . in deaths or disability primarily due to deformity or unexplained prematurity, the powers of the pediatrician are very limited, chiefly because the pattern of behavior is to a certain extent defined in extremely early pregnancy."

Dr. Samuel Kirkwood, formerly of Harvard and now Commissioner of Health for Massachusetts, provided additional evidence to back Dr. Walker's theories in a report on a nutritional study of 216 women, made by Bertha Burke of the Harvard School of Public Health. Mrs. Burke's findings showed that all types of stillbirths and major congenital deformities, and all but one of the causes of deaths within the first week of life, were found among babies of underfed mothers.

The conference also examined evidence indicating the part played by various environmental factors in the production of anomalies in infants, in the hope of finding some way of lowering still further the newborn death rate. This rate in most Western countries has dropped from between 30 to 40 per 1,000 live births in 1928, to 20 per 1,000.

Professor John Lind, of the Department of Physiology, Norrtulls Hospital, Stockholm, Sweden, presented an unusual motion picture depicting the first breath of a newborn infant. In reporting on how this was made, Professor Lind said that infants who had not yet

started to breathe were placed upon a fluoroscope screen. Radiation of a very low intensity was turned on and the image picked up by television was intensified. The face of the television screen was photographed at a speed of 40 frames a second on movie film.

The film showed first the tiny rib cage of an infant just after birth with the shadow of the enlarged heart in the center of the screen. With the first breath air filled the lungs and at that moment the heart shadow shrank as its content of blood was drawn into the now inflated lungs. Then the lungs emptied and the heart increased in size as normal flow of blood started from the lungs back into the heart. Regular breathing and heartbeat then followed.

Dr. Samuel R. M. Reynolds of the Carnegie Institution of Washington, chairman of the conference, suggested that the method used in making these motion pictures might be of great value to researchers in their search for ways to prevent the crippling afflictions that arise from accidents at or near the time of birth.

In another report Dr. Ross A. McFarland of the Harvard School of Public Health told of studies indicating that the characteristics of an individual's breathing may be as unique as his handwriting. These produced some evidence that breathing patterns established in infancy may persist throughout life. Irregularities in breathing may reflect emotional abnormalities, Dr. McFarland suggested, reporting that there is some correlation between an unstable personality and a tendency to rapid, shallow breathing. Other members of the conference compared this finding with those of similar studies conducted on wartime pilots in which all steady and competent pilots were found to be deep, slow breathers.

The discussions of these and other significant studies on the causes of prematurity and congenital malformations will be reported in detail in the conference proceedings now being prepared by an editorial committee headed by Dr. Reynolds.

Leonard Mayo
Director, Association for the Aid of Crippled Children, New York

Cost Analysis

The method of cost analysis developed for family agencies by John G. Hill, research director of the Philadelphia Health and Welfare Council, was recently applied to two privately financed children's agencies in Pennsylvania in studies prepared by graduate students of social work at Bryn Mawr College. The studies required adaptation of Mr. Hill's proposed cost centers (described in THE CHILD, November 1953) to the functions of the specific children's agencies under scrutiny. For instance, at the Delaware County Children's Aid Society, one of the agencies studied, these were classified as: Counselling Service, Pre-Adoption Service, Temporary Short Time Care Service, Long Time Care Service, Special Care Service, Student Training, and Participation in Community Planning. Collateral cost centers included Foster Home Finding and Licensing, Staff Education and Development, Public Relations, General Administration, and Research.

Time studies of each staff member against these classifications revealed costs, incurred to maintain agency standards, that were not identified in the agency's budget appropriations. Similar findings emerged in the study of the Lehigh County Children's Aid Society, the other agency involved.

Physical Therapists

Beginning this fall California's Board of Medical Examiners will examine physical therapists who are seeking certificates of registration.

California, which established a register for physical therapists a year ago, is the most recent State to do so. Nineteen States and the Territory of Hawaii now have such registers, with laws prohibiting use of the title, "registered physical therapist," by any person not listed with them. In six of these States—Arizona, Maryland, New Mexico, New York, Pennsylvania, and Wisconsin—practice of physical therapy by unregistered persons is forbidden by law.

Adoption

Three years of effort "by lay citizens for the benefit of lay citizens" are represented in the Final Report of the Citizens Committee on Adoption of Children in California. Completed in 1953, the work was financed by the Rosenberg and the Columbia Foundations. Its goal was "to improve and extend adoptions and related services through the development of public opinion in relation to what constitutes the proper protection and care of children."

The State committee and 12 county committees grew out of a conference on adoption problems called in 1949 by the Los Angeles Welfare Council and the welfare plannnig bodies of San Francisco, San Diego, and Oakland—all concerned over a growing public resentment of adoption-agency practices which had accompanied a greatly increased demand for babies to adopt. Part of this resentment came from a widespread belief that institutions and foster homes were full of adoptable children.

At the request and with the financial assistance of the State committee the Los Angeles County Committee gathered information on more than 3,000 children in boarding homes and institutions in the county who had been placed by social agencies—but did not include the 14,000 other children in boarding homes and institutions in the county who had been placed by their own parents.

The Los Angeles County Committee reported than 12 to 18 percent of children studied were "in need of adoption planning" though only 2.5 percent were at the time legally free to be adopted. It also reported that inadequate adoption services in the past had resulted in a backlog of children in foster care. However, it put the major blame for the large number of children away from their own homes on an insufficiency in community services to help families keep their homes intact or to rehabilitate them so that children in foster care might be returned home.

The State committee investigated the State adoption laws and found them good, except for inadequacy in provisions to help unmarried mothers. It recommends a change in the statutes to remedy this defect and offers specific suggestions for improving adoption services to protect the children, natural parents, and adoptive parents, and for provision of better welfare services generally in the community. A complete adoption service, the committee found, is dependent on the availability of related welfare services.

New protections for persons involved in adoptions have applied in Virginia since July 1, when 1954 amendments to the State adoption laws became effective. These reduce from 2 years to 6 months the period in which the validity

of an adoption can be challenged. They also provide that an unmarried mother's consent to adoption is not valid unless given at least 10 days after the birth of the child, thus minimizing the chances of her giving up her child under duress while she is still suffering the effects of delivery.

Needy Children

California's State Department of Social Welfare is taking steps to improve its services for children in boarding homes and institutions who are receiving assistance under the State program of Aid to Needy Children, which includes the program known in other States as Aid to Dependent Children. These children represent fewer than 10 percent of all children on the ANC rolls, but the Department points out that their problems have not received the same attention as have those of the children living with their mothers or other relatives, partly because they represent such a small proportion of the total caseload. Most of the procedures followed in carrying out the ANC program were planned for the larger group, acording to the Department, and therefore it is now developing patterns of administration to meet more adequately the needs of the children away from home.

Failure to meet these needs, the Department finds, is associated with a number of factors, among them: differences in interpreting the extent of county responsibility for serving children; insufficient efforts to keep children with their own families; failure to include parents in planning; inadequate planning for children going into foster care; failure to prepare older children for the time when they will be "on their own."

The Department plans the following steps to remedy these and other deficiencies:

"(a) Guide material will be developed to assist the local agencies in applying the regulations '. . . to keep children in their own homes wherever possible and to provide the best substitute for their own homes for those children who must be given foster care.' One project will be the preparation of a handbook to include a set of working principles to help county staff in dealing with the children, parents, and foster parents, as well as methods to help agencies in working with each other.

"(b) A standard to assure adequate care for children in foster homes will be developed.

"(c) Guides specifically aimed at helping the older children prepare for eventual self-maintenance will be developed.

"(d) Analysis will be made of the 'patterns of administration' to determine which appear to be the most workable and efficient in meeting the problems of this group of children.

"(e) Assistance will be given to counties in those areas of administration of the program which can be improved."

Most of the improvements planned can be carried out under existing statutes, the Department says, although some will depend on changes in the law.

Canadian Social Workers

In Canada, as in the United States, schools of social work have been able to turn out trained social workers in sufficient quantities to fill only a small portion of the positions in public and private social agencies. The disparity between staff needs and the availability of professionally trained persons is made clear in a report recently published by the Canadian Department of National Health and Welfare.

Based on a survey of social work positions in 1949–51, similar to the 1950 study made in this country by the United States Department of Labor, Bureau of Labor Statistics, the report shows the proportion of professionally trained persons to be only 30 percent of all personnel in social-work positions in agencies and only 5 percent of such positions in institutions. The 250 graduates of Canada's schools of social work entering employment each year are not sufficient for the replacements necessary to keep this proportion relatively static.

The survey covered 4,909 positions in most of the voluntary and public agencies and institutions in Canada.

Cerebral Palsy

Since lack of sufficient oxygen at birth may damage an infant's brain and thus cause cerebral palsy or even death, United Cerebral Palsy is financing an effort to develop a test to show when the oxygen level sinks to the danger point. This is one of 32 research projects being carried on at various universities and other institutions through UCP grants.

Another project aims to discover whether incompatibility of blood groups in parents can lead to cerebral palsy in their child.

A clue to a third possible cause of cerebral palsy—virus infection of the mother during pregnancy—is being sought in another study.

Two educational-research projects are also included, the first in UCP's 5-year history. One is a study of the language process of preschool cerebral-palsied children; the other, a comparative study of attitudes of cerebral-palsied children toward school.

Mental Health

New York State's Department of Mental Hygiene has established a new division, the Community Mental Health Service. This division will coordinate a new long-range program, provided for through 1954 legislation, with existing community mental-health activities. The new plan provides for creation of local mental-health boards and establishment of local mental-health services with State aid. These services may include psychiatric clinics, psychiatric facilities in general hospitals, rehabilitation of recuperating mental patients, and consultant and educational services to schools, courts, and health and welfare agencies.

Family Life Education

A 10-year program for expanding and intensifying its educational services has been begun by the American Social Hygiene Association with the help of a grant by the Nancy Reynolds Bagley Foundation. Some of the measures to be taken by the association under this program with regard to education for personal and family living are: To produce and distribute materials for parents, religious leaders, educators, and other youth leaders; to cooperate with other organizations similarly concerned; to sponsor research; and to organize regional projects, each aimed at stimulating three or four States to work together in focusing on the need for adequate preparation of teachers on problems of personal and family living.

Mentally Retarded

With a State appropriation of $50,000 the New York State Mental Health Commission is beginning a pilot study to determine the extent to which severely mentally retarded children can be

ducated and trained. The study is eing conducted in 12 classes for such hildren. Five of these classes are in schools under the jurisdiction of the tate Department of Mental Hygiene; he other 7 are in city public-school ystems.

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The National Association for Re-arded Children, an organization of arents with local affiliates in more han 40 States, has recently issued a amphlet suggesting a program for raining the mentally retarded child. Each suggestion has resulted from par-nts' questions and each has been suc-essfully tried, say the authors, Naomi I. Chamberlain and Dorothy H. Moss. "The Three R's for the Retarded; re-etition, relaxation, and routine." The Association, 129 East 52d Street, New York 22, N. Y. 50 cents.)

Parent Education

About half the parents queried in a recent study of prekindergarten attend-nce approved of parent education as part of the nursery's program, and even more would like to have had op-portunities for parent conferences, par-ent meetings, and parent observation of the children in the group.

The study, directed by Dr. Catherine Landreth, University of California, and jointly sponsored by the Rosenberg Foundation and the California Commit-tee for the Study of Education, showed that only 14 percent of the 8,000 Cali-fornia first-graders involved had at-tended nurseries or nursery schools, though nearly half the parents would have liked their children to have the experience.

Children and TV

Interviews with more than 600 fam-ilies in a small Eastern city indicate that the majority of parents approve of the television programs now being offered children, though many families have some specific objections.

In a study made under the auspices of the National Council of Churches of Christ in the U. S. A. and Yale Divinity School, interviewers collected various social data from a 5-percent random sample of the population of New Haven, Conn., and its suburbs, and found 650 families with minor children, and tele-vision sets. These families were ques-tioned about their children's television viewing and the parents' attitude to-ward the programs that were available.

Nearly half the pareuts gave unquali-fied approval to the programs; about a fourth approved, but wanted changes; and the remaining fourth disapproved totally.

Parents who offered suggestions wanted such changes as more programs suited to preschool children; less vio-lence; more educational and religious program; better scheduling of favorite programs to avoid conflict with suppertime.

The average time spent regularly by children 4 through 15 years of age in watching programs was reported by the parents as 13 hours a week. Nearly half of this time was said to be devoted to children's variety programs, some-what more than a third to Westerns, and less than one-tenth to adult programs.

The report notes the fact that the children undoubtedly watch more adult shows than the small fraction reported by parents. Parents "were reluctant to report such viewing, especially in the evening. . . . The children themselves, however, not only reported viewing adult evening shows but could report their conteuts accurately."

Juvenile Delinquency

North Carolina's Board of Public Welfare reports that, in contrast to the average picture for the Nation, juvenile delinquency in that State is not in-creasing.

As evidence of this, the Board points to the fact that in two decades no in-crease has taken place in the number of delinquency hearings before juvenile courts in relation to population of juv-enile-court age (11–15 in North Caro-lina). In the 5-year period ended June 30, 1934, the State had 6.7 juvenile-delinquency cases per 1,000 persons 11–15 years of age in the population. In the most recent 5-year period for which data are available (1948–52) the figure was slightly lower, 6.2. Thus, although some variations took place in individual years, the incidence of ju-venile delinquency in the State has re-mained substantially the same siuce the thirties.

The Board also reports that serious offenses charged to juveniles are fewer than they were 15 and 20 years ago, that fewer children are held in jail, that the number of children in training schools is declining. Juvenile delin-quency is negligible among children in families receiving Aid to Dependent Children grants, according to North Carolina records.

The Board suggests that these facts may be partly accounted for by the expansion and improvement of North Carolina's child-welfare services.

Here and There

Pennsylvania citizens concerned with the problems of the State's 60,000 de-pendent and neglected children have recently united in a nonpartisan move-ment called the Roll Call for Children, with a three-point program: (1) to ac-quaint the public with facts concerning the problems of child dependency and neglect in the State; (2) to encourage expansion of all services—voluntary and public, sectarian and nonsectarian, local and statewide—to meet the urgent and immediate needs of neglected chil-dren; (3) to work toward the adoption of necessary changes in State law to facilitate expansion of services and ac-ceptance of proper standards of child care.

• • •

Controlled fluoridation of drinking water for the purpose of reducing den-tal caries in children is now in opera-tion in 1,000 communities in the United States and its possessions, with a total population of 18 million.

• • •

Births in the first 6 months of 1954 are estimated by the National Office of Vital Statistics as 1,940,000—registered and unregistered. This is 45,000 more than the births during the same period in 1953. Much of this increase, accord-ing to NOVS, can probably be attrib-uted to a continuing rise in the num-ber of third and fourth children. Be-cause of falling marriage rates since 1951 an increase in first births is not expected.

• • •

The National Electrical Manufac-facturers Association and the National Safety Council have undertaken a joint educational compaign to prevent chil-dren from becoming trapped in aban-doned refrigerators. Among the mate-rials thus far produced is a fact-finding sheet about the hazards of discarded iceboxes and refrigerators and a small poster to warn children against playing in them.

IN THE JOURNALS

"Overstuffed babies"?

In 22 lively pages the QUARTERLY REVIEW OF PEDIATRICS (May 1954) gives the results of its nationwide survey of "Trends in the Early Feeding of Supplementary Food to Infants," and the comments thereon of a number of widely-respected pediatricians. The emphasis is very much on the "early." Dr. H. L. Barnett thinks that the present earlier introduction of solid foods is apparently related to "the questionable principle" that if a food is nutritionally good, the more of it an infant can retain "without gross signs of toxicity" the better.

Dr. Harry H. Gordon fears that some mothers may, in trying to follow their doctors' suggestions, end up in 6 months with "overstuffed obese babies" who can't possibly go on gaining so fast. Dr. Charles D. May considers that it is up to those who recommend early solid food to "demonstrate real advantages." "The too early addition of added carbohydrate (cereal)," remarks Dr. B. M. Kagan, "may cut down on the volume of milk taken, with its essential contribution of calcium." Dr. Lee Forest Hill suggests that "there is no advantage to introducing solid foods . . . before 3 months of age at the earliest," and that there may be disadvantages.

Dr. Milton J. E. Senn appraises the findings of the survey, which he says, "points up two ominous trends"—the insistence of mothers on giving their babies additional food, regardless of readiness for it, which grows out of an urgent desire to speed up the development of their children; the acquiescence of many physicians to this.

The ways of suburbanites

In "The Separation of Home and Work," in SOCIAL FORCES (May 1954), Leo F. Schnore of the University of Michigan presents the findings of research on the effects of suburban life on living habits, including such factors as ride sharing, the costs of family purchases in outlying areas, the effects of part-time food raising by factory workers on their work-shift preferences. The article does not directly discuss the effects on children and family life, but such overtones are suggested by some of the facts presented—such as the extra hours suburban fathers spend away from home.

The doctors learn, too

When parents of children who have nephrosis or diabetes get together in discussion groups at New York Hospital-Cornell Medical Center they help each other, in addition to getting information and reassurance from the pediatricians who meet with them.

Doctors Barbara Korsch, Lewis Fraad, and Henry L. Barnett, in the JOURNAL OF PEDIATRICS for June 1954, tell frankly of the "individual resentment and diffuse, ill-defined hostility against the medical profession" that spill over when they first have "Pediatric Discussions with Parent Groups." But they find that the anxiety, so natural in these parents of ailing children, is better relieved by group discussions in which similarly burdened parents take part than through the reassurance given individually. Parents can accept, for example, the fact that their children's disturbing resistance to insulin injections is temporary when a parent who has been through the mill tells them so. The article points to the hazards of this group method as well as the benefits to staff and parents.

Airborne fluorides

"Effects of airborne fluorides on children living on Sauvie Island" is the intriguing title of a study reported in the JOURNAL OF THE AMERICAN DENTAL ASSOCIATION for July 1954, by B. S. Savara, Harold Judd Noyes, and Theodore Suher. Were the fluorides, presumably coming from aluminum reduction plants at Vancouver, being assimilated by children through inhalation or through food and water to a harmful or beneficial degree?

The findings: "The daily intake of fluorides was so low that it did not cause mottling of the teeth nor alter the incidence of dental caries." No evidence was found that the children had "consumed excessive fluorides," although "the presence of fluorides in the atmosphere is alleged to have caused damage to the cattle and vegetation."

"Advice isn't the word"

The 16-year-old boy who said this was trying to express what it had meant to him to have some backing in making a new beginning. He decided that what had helped was that he felt he had been "a part of something." Mazie F. Rappaport devotes 25 of the rather small pages of the annual JOURNAL OF SOCIAL WORK PROCESS for 1954 to a discussion of "The Possibility of Help for the Child Returning from a State Training School." The specific efforts she describes are those of the After-Care Supervision Program which the State of Maryland provides for boys and girls leaving training schools.

Family life for crippled children

It is not surprising that Vermont's plan of family living for crippled children receiving care at its Rutland rehabilitation center should be as individual as the scenery and characters in that State. In "Affection by Proxy" Dorothy Smithson and Emily B. Sheldon describe in THE CRIPPLED CHILD for June 1954 how Vermonters thriftily avoided putting money into institution residence and provided children who must leave their own communities for treatment something no granite-faced building could have furnished—the warmth and intimacy of life in a family setting. In 5 years 59 crippled children have been placed in 28 foster homes. An encouraging outcome is that new foster parents often materialize as a result of having seen what some neighbor was able to do for a child.

Group learning

Cooperative exploration and discovery is the basis for a course in the department of psychiatry at the University of Pennsylvania School of Medicine, in which students have the "opportunity to see in operation various phenomena and processes which are important between people." In the July 1954 issue of MEDICAL EDUCATION Kenneth E. Appel and Margaret M. Heyman display "The Psychiatric Social Worker in Group Process Teaching," and show glimpses of what happens to students, sometimes slow to accept the method, and of how the instructors' personalities aid or hinder the worker's aims.

SOME U. S. GOVERNMENT PUBLICATIONS FOR PROFESSIONAL WORKERS

Publications for which prices are quoted are for sale by the Superintendent of Documents, United States Government Printing Office, Washington 25, D. C. Orders should be accompanied by cash, check, or money order.

THE NURSE'S ROLE IN THE MENTAL HEALTH PROGRAM. Mary Corcoran, R. N., Esther Garrison, R. N., and Pearl Shalit, R. N. Department of Health, Education, and Welfare, Public Health Service, National Institute of Mental Health. 16 pp. 15 cents.

After listing some basic mental-health concepts, this booklet suggests how a nurse can make a more conscious and more effective contribution to the field of mental health. It tells how she can provide emotional support to her patient; how she can help build mental-health resources. Source materials—books, articles, and audiovisual aids—are listed.

GUIDE TO GOOD PRACTICES IN YOUTH DAY-HAUL PROGRAMS SUCCESSFULLY USED IN AGRICULTURE TODAY. U. S. Department of Labor, Bureau of Labor Standards. 1954. 12 pp. Processed. Single copies available without charge from the Bureau of Labor Standards, Department of Labor, Washington 25, D. C.

In a youth "day-haul" program, as defined in this bulletin, groups of young people from cities and towns are picked up daily during their summer vacation from school and taken in trucks or school buses to the fields to harvest crops, as a means of meeting farm-labor needs.

The bulletin recommends standards for such a program with regard to the age and physical fitness of youth selected; written consent of the parents; safe transportation; hours of work; wages; health, safety, and sanitary facilities; and supervision.

In preparing the bulletin the Bureau of Labor Standards received the advice of the Farm Placement Service of the Bureau of Employment Security, U. S. Department of Labor; the Children's Bureau, the Office of Education, and the Public Health Service, U. S. Department of Health, Education, and Welfare; the Federal Extension Service, U. S. Department of Agriculture; and the State and Local Officials' National Highway Safety Committee.

HOMEMAKER SERVICE; a way of helping the long-term patient. Conference on Care of the Long-Term Patient, March 18–20, 1954, Chicago, Ill. Report of the Study Group on Homemaker Service. U. S. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. 23 pp. April 1954. Processed. Single copies available without charge from the Children's Bureau.

Information on 50 agencies giving homemaker services, obtained through a questionnaire and other sources, is summarized in this report by a study group composed of a physician, a public-health nurse, a medical social worker, 3 social workers with degrees in home economics, 2 citizens active in public-health work, an executive of a local committee on the chronically ill, and a consultant on homemaker service on the staff of the Children's Bureau.

HOME ACCIDENT PREVENTION; a guide for health workers. Federal Security Agency, (now the Department of Health, Education, and Welfare), Public Health Service, Division of Sanitation, of the Bureau of State Services. PHS Pub. 261. 1953. 75 pp. Single copies available free from the Public Health Service.

The Public Health Service has published this outline in response to requests for material on prevention of home accidents, to be used in preparing persons planning to enter public-health work—physicians, nurses, sanitary engineers, health educators, and others. A section on accidents to children is included.

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A PROFESSIONAL JOURNAL ON SERVICES FOR CHILDREN AND ON CHILD LIFE

U. S. DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
Oveta Culp Hobby, *Secretary*

SOCIAL SECURITY ADMINISTRATION
Charles Schottland, *Commissioner*

CHILDREN'S BUREAU
Martha M. Eliot, M. D., *Chief*

NOVEMBER · DECEMBER 1954

children

A PROFESSIONAL JOURNAL ON SERVICES FOR CHILDREN AND ON CHILD LIFE

Interprofessional Understanding

Factors in Mental Retardation

The Polio Vaccine Trial

Services in the ADC Program

VOLUME 1
NUMBER 6
NOVEMBER–DECEMBER 1954

In her coeditorship of the fact-finding report for the Midcentury White House Conference on Children and Youth, Ruth Kotinsky exemplified her long-time concern with bringing together the contributions of the various professions to the development of the individual child. A distinguished writer on education, she has served on the National Council of Parent Education and on the staff of the Committee on Secondary School Curriculum for the Progressive Education Association.

Dr. George A. Jervis, who introduces CHILDREN'S series on the mentally retarded, has been working in the field of mental deficiency for the past 20 years. At Letchworth Village one of the oldest and largest State institutions for the mentally retarded in the country, he has had at first hand an abundance of material for his inquiries into the etiology and characteristics of the various types of mental defectiveness.

The research, professional training, and patient-care programs of the National Foundation for Infantile Paralysis all come under the direction of Dr. Hart E. Van Riper who herein describes the recent widespread testing of the Salk vaccine. With the Foundation since 1946, this administrating pediatrician was from 1941 to 1944 director of maternal and child health in the Children's Bureau, then in the Department of Labor. Later he served as medical director of a hospital in Miami, Florida.

The coauthors of the article on services to children in the ADC program have both had long experience in public welfare services. Before joining the staff of the Children's Bureau 8 years ago Mrs. Sandusky (left) had been consultant on children's services with the Illinois Public Aid Commission and head of the casework department of the Atlanta University School of Social Work in Georgia. Miss Foster (right), with the Bureau of Public Assistance for 3 years, was previously supervisor of field services for the Washington State Department of Public Welfare.

An expert in quantitative analysis, Edward E. Schwartz in this issue tells why available figures on juvenile delinquency are not entirely reliable. Demonstrating the usefulness of statistical methods has absorbed a major portion of Mr. Schwartz's attention in his 13 years with the Children's Bureau and in the 5 years he spent as regional consultant for the Bureau of Public Assistance. His M. A. is from the University of Pittsburgh.

Considerable first-hand experience in well-child conferences has convinced Marie Goik of the importance of understanding the emotional and social factors which affect a mother's relationship to the child. Before taking her present position, she was Nurse Consultant in a Commonwealth Fund project on mental health services for children in the University of Louisville School of Medicine, Louisville and Jefferson County Department, and Kentucky State Department of Health.

Widely known as a parent-group leader and speaker on human development and mental hygiene, Ralph H. Ojemann is directing a research project in education in human relations and mental health.

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A professional journal on services for children and on child life (*formerly* THE CHILD)

frontispiece

NEW HOPE for the prevention of poliomyelitis which has left this little girl with partial paralysis is centered on the vaccine tests described elsewhere in this issue. But even though the vaccine proves completely reliable and is widely adopted as a public-health measure, large numbers of victims of past scourges of the disease will still require treatment and rehabilitation. Such services are today provided both by the National Foundation for Infantile Paralysis and the State crippled children's services, the division of responsibility depending on individual State agreements with the Foundation. In 1953, some 30,000 children under 21, many of whom had contracted the disease in previous years, received service for the acute or later effects of poliomyelitis from the Crippled Children's Services. In that year there were approximately 36,000 new cases of the disease among children and adults.

—Photo by Esther Bubley for the Children's Bureau.

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Good service requires good teamwork among various professions. Here is suggested . . .

AN APPROACH TO INTERPROFESSIONAL UNDERSTANDING

RUTH KOTINSKY, Ph. D.

Former Assistant Director of Fact-Finding, Midcentury White House Conference on Children and Youth

ALL THE PROFESSIONS that deal with human beings aim to help them achieve the utmost of their potential for living not only adaptively but also creatively in their society, participating in it as fully as they can, and achieving optimum satisfactions in the process. Broad aims held in common are likely to lead to the presupposition of broad common professional understandings—presupposition of a wider common background than the facts of professional education warrant.

For example, the teacher has to know how the child develops and so does the social worker. Both have had training in this area, and so presumably have at least this much in common. Actually, most teachers have been schooled in a brand of child development that emphasizes the kinds of behavior to be anticipated at various ages or developmental levels, without interpretation of observable phenomena or rationale for their sequence, whereas social workers have ordinarily been steeped in what has come to be known as "dynamics."

Each talks to and with the other as if they held a common understanding, when in fact they do not. Actually each is an adherent of a different school of thought about human behavior and what gives it its characteristic bent. And when two persons, each with a different theory of behavior, try to work together with regard to the behavior of a third, trouble is bound to brew—most importantly perhaps for the third, but also in the relationship between the two.

Then, in part because of an actual lack of understanding of the dynamics of development and behavior on the part of teachers, and in part because the schools have of late become so avid for mental-health furbishings, the social worker (or occasionally the clinical psychologist or psychiatrist) has had a try at imparting new insights and understandings to teachers and principals. Here all the resistances to being moved in on by an "outsider" come into play. Moreover, in this effort, the social worker is scarcely in a position to follow what is perhaps the first rule of teaching, namely, to begin where the learners are.

He does not have at his command the whole conceptual framework that lies behind the teacher's teaching and the principal's conduct of the school. He cannot therefore build upon it, helping teachers to reconstruct it where they think necessary after having been exposed to new knowledge and brought to new sensitivities through their contact with him. Unaware of a conceptual framework, he is all too likely to speak as though it were not there. It is impossible for him to distinguish between the educational ideal and its all too imperfect realization.

It is, for example, no longer necessary to explain to a teacher that a child is best approached with respect rather than with hostility and contempt, and that any approach to him must be geared to his current level of development. These have been theme songs in his education as a teacher. If he still does not treat his pupils with respect and adapt to them as children, as indeed he may not, the reason must lie elsewhere than in his training, and one more lesson is not very likely at last to turn the trick.

This article is excerpted from a paper presented at the 1954 Forum of the National Conference of Social Work.

Social work is often an adjunctive, and nearly always a cooperative, service; but an adjunctive service is impeded, and cooperating services lose much that they might gain, as long as the different services start from different premises, taken as axiomatic, about the sources of human behavior. When to this there are added a general lack of sociological information about the potentialities and limitations of professional groups and institutions for bringing about social change and some vagueness with regard to the spread and limits of specific professional function, the possibilities for interprofessional irritation are many, and the need for some drastic interdisciplinary setting of the house to rights is thrown into sharp relief.

Contrary Assumptions

Each institution and profession consciously directed toward the shaping of human behavior has grown up out of specific social exigencies, has been shaped by different influences, has developed its own tradition, values, mores, sacred cows and taboos, language, assumptions taken as axiomatic, framework of deduced conceptions, ingroup cohesion and outgroup antagonisms. Among such islands, communication tends to be blotted out by static.

If assumptions in regard to the forming of human behavior were readily put to the test we should be in no such great difficulty. The assorted disciplines that treat of the physical and biological worlds are not so bedeviled by basic assumptions that lie sometimes contrariwise, the one to the other, and sometimes obliquely, in bewildering patterns and frustrating *culs de sac*. Each may have its own symbols, but semantic problems are practically nil because each symbol either has a direct operational referent, or a defined relationship to other symbols which have such referent in the outer world. When a problem calls for cross-fertilization from two such fields, like chemistry and biology, there is no great pother of misunderstanding, misinterpretation, working at cross-purposes, and mutual denigration. It is necessary only to contrive methods that bridge the mutually accepted assumptions.

For the sciences that bear on human behavior there is as yet no methodology for moving past all possible or probable doubt. Some clinical evidence there is, but that is empirical only, and concentrated largely on deviate or pathological instances. Some laboratory evidence there is, but man is a social and not a laboratory animal. Unlike other animals, he lives only in and through a cultural medium. Some statistical evidence there is, but it must be highly suspect because human behavior, insofar as it is understood at all, seems in no way reducible to discrete units, the very stuff of statistical method. Out of much experience with an assortment of approaches, none of them either entirely appropriate to their material or entirely satisfactory as science, a new Bacon of the sciences bearing on the behavior of man may emerge. But that time is not yet.

What then of the meanwhile? The interdisciplinary approach has long been bespoken, and has as yet, as far as I know, nowhere fully succeeded. Yet it seems to me of such great worth as to warrant still more tries, with as great resources as can be found to back them up, and as much preexploration of the difficulties as possible. This I call to the special attention of the profession of social work, in part because it draws upon a number of disciplines, but so do all the other arts of healing, amelioration, and guidance. More especially, the opportunity seems challenging to social work for two other reasons. One of these is enduring: Since much of professional social-work practice is adjunctive, of necessity, social work operates often in the context of assumptions other than its own, and in a number of such contexts, each of which differs from the other. This in itself provides opportunity, stimulation, and challenge. The other reason for posing this problem to the field of social work is more ephemeral: The fleeting moment of setting the pattern of its doctoral work is at hand.

The interdisciplinary approach in professional education already has been tried in several ways. A relatively time-honored one is to throw several books at a young student at once, and leave the job of integration to him, as though to say, "We seasoned folk can't make it; you try." In this implied exhortation there may be a grain of wisdom, but the fact of the matter is that the young student has neither the capacity nor the occasion to try. Somebody lectures in psychology; somebody else lectures in sociology; somebody else lectures in anthropology, and maybe history and economics and the dynamics of behavior. It is all very interesting, and if one is very bright, one can keep this whole assortment of hats around to pull something out of when one phenomenon or another needs explaining. The fact that the hats don't fit together very well is of no immediate concern.

Another system consists of steeping a student in a stimulus-and-response psychology, trial and error,

fumbling and success, assuring him that this is the way all learning takes place, and that learning involves the reconstruction of the self—and then sending him out to observe in a guidance clinic that rests upon quite other premises about the nature of the self and the ways in which it changes. Here again are a couple of hats into which he can dip at will.

Other attempts have been made much further along the scale of professional maturity. These have been of many different orders. Sometimes a covey of scholars from assorted fields has been brought together for a short time in order that the translucence of each and all may illumine a given project. Ordinarily, it takes much editorial legerdemain to obscure the resulting Babel. More occasionally mature scholars have come together over long periods of time, seriously dedicated to joint study and research. Most often they have soured, sickened, and eventually turned in desperation each to his own laboratory in order once again to have the feel of getting something done.

This is where the bit about "We can't do it; you try"; fits in. The mature professional has apparently given himself in hostage to the skills and techniques, horizons and perimeters that have served him well to date. All the books on adult learning say that this should not be so and need not be so, but apparently in the vast majority of cases it is so nonetheless. Efforts to widen the horizons in ways that may necessitate acquiring new skills or overhauling old ones prove threatening, and tend to be met with resistance, either overt or in the form of a profound apathy.

It would begin to look, then, as though we must revert to the young student whose professional self is not yet formed, and surely not hardened into a rigid mold. Insofar as we have succeeded in integrating the findings from the assorted disciplines related to the study of human behavior, these integrations can, of course, be passed along to successive generations of students. But the day on which we shall have very much such integration seems still far off. In the meantime, it would seem the better part of wisdom to acquaint students—probably even undergraduate students, but surely graduate students—with the discrepancies among the disciplines, the *lacunae* in our knowledge, the extreme tentativeness of all the hypotheses on which all workers in the area of human behavior must now operate.

This of course is being attempted in some places. In time, it may obviate some of the hard-set-in-a-moldness that now seems to characterize too many of those advanced in practice. Also, for some students, it will pose a challenge which might otherwise elude them, and so stimulate to research at profounder levels as the years go by. There is, of course, the possibility that action will be paralyzed if the grounds upon which it rests are early recognized as shaky, but this possibility seems to me remote.

Somehow the field of biology survives, and active and fruitful work goes on within it, despite the fact that students are introduced early to the evidence that leads to various and differing theories of evolution. Moreover, in everyday life, decisions are made hourly without sufficient evidence to go upon. Man acts because he has to act.

An Opportunity

So far I have been thinking about students below the doctorate level. It would be my guess that if such students were versed in the theoretical discrepancies upon which all practice relating to human development and behavior rests, they would, when the time came for them to practice, arrive at mutual understanding more readily, and that the articulation of their efforts would prove more beneficial for those whom they are trying to help and more enriching and mutually rewarding to themselves.

But still little would be accomplished toward the integration of basic theory. Here is where, hopefully, the new social-work doctorate comes in. By long and respectable tradition, the doctoral candidate must make a contribution to knowledge. By another long and less respectable tradition in fields relating to human behavior, this basic requirement has been reduced to a travesty. A contribution is equated with research; research is defined as the employment of research techniques; research techniques are borrowed from fields where they belong and applied in a field to which they are not opposite. The only urgent problem the student really feels is to get his degree, and the Ph. D. candidate in search of a problem to which the research techniques he is obliged to use can somehow be applied is unfortunately not a rare academic bird. In the long run he usually hits upon something, no matter how trivial, puts his tools to work, and comes up with a correlation coefficient plus or minus something. By definition, he has made a contribution to knowledge. Under these ground rules, both Bacon and Darwin would have flunked.

It is easy enough to say that there are not many Bacons or Darwins among candidates for the doctorate. It is harder to set the stage for the emergence of some potential Bacon or Darwin. There is, of

course, a need to train a certain number of people for administrative posts and for a kind of evaluative research which, however crude, is the best now available for gaging the worth of programs and giving direction to practice. People have to be trained; once trained, they have to be certified as such, and perhaps this is what most doctorates must continue to represent.

My sole plea here is that, in all professional fields that bear on the behavior of man, some major emphasis be put upon seeking more genuine contributions to knowledge through the interdisciplinary approach. This would call for rich resources, and not in money alone. It would siphon off the most sensitive, insightful, intelligent, and creative of candidates, and it would be doomed to failure if faculty members, plagued by committee meetings, had no time for the arduousness of scholarship or no stomach for its frustrations. It would also demand the sacrifice of one of our sacred cows, according to which it is wicked even to whisper: "We do not know. We do not yet have the evidence for certainty. We have come upon some obstacles that have us stopped for the time being."

Possible Inquiries

The lines of investigation that might be pursued are manifold. A delineation of basic assumptions taken as axiomatic in any and all fields of related practice is one. It would involve their systematic examination and the attempt to array them as alternative hypotheses, despite all semantic bedevilments. It would lead eventually to an extended search for methods of testing these hypotheses.

There is also much to be learned about how institutions arise and take and change their characteristic forms, and about the role of the professions in this connection. In the long run we must know whether to fish or cut bait on our professed professional obligations to contribute to the orderly amelioration of the shape of social things. With better understanding of how human beings develop and change and how social institutions develop and change—or even with no more than a clearer grasp of alternative hypotheses on this score—it should be possible to delineate far more clearly the distinctive contribution of each professional field to shared goals in terms of human values.

All this will entail full use of the resources that lie in a university. Clearly a good deal of the inquiry proposed will have to be conducted in an interprofessional setting. But all these professions rest, each in its own way, upon the findings in a series of so-called "pure sciences" or disciplines—psychology, sociology, anthropology, and all the rest, all fully represented in the university. Therefore, if inquiry is to plumb beneath the surface in any of the professions, it must needs proceed hand-in-hand with the supporting pure disciplines.

The use of university resources after this fashion is undoubtedly far easier said than done. The university has its own traditionalisms, as does each school and department within it. Professional acculturation is perhaps hardest-shelled in the university, where it is to a degree protected from the stubborn unclassifiability of social life on the hoof. Hard-gained techniques and cherished axioms are less threatened when the academic walls are built high around each school and discipline. Moreover, one folk axiom is hard to call into question—"once bitten twice shy"—when it comes to interdisciplinary effort.

On the other hand, the university tradition is made up of assorted strands, and one of these that still stands out bright in the pattern is the rigorous search for truth. The rigor need not represent only implacability in face of the spurious, but also an inflexible determination that no half truth shall stand so long as a larger fraction may be found. No doctoral candidate with a truly searching problem, a rich background, and some evidence of genuine creativity should find himself out in the cold when his work requires the concerted critique of scholars from a number of disciplines. And the same should hold of research conducted by any advanced professional school in a field where problems are many and complex, action is imperative, and gaps in knowledge are in many respects absymal.

Doctor's theses in these circumstances will necessarily take on a tenor quite other than their currently monotonous clatter of computing machines, and a design that must reach further than the agglomeration of pious footnotes. Fewer will come up with answers. More will come up with questions. Some may have to give serious account of why not even useful questions could be formulated. The risk that a fraction of them will turn out pure balderdash will have to be taken, and consolation found in the fact that the fraction will probably be no greater than under the present stereotype. The whole will be a severe headache and a test of human endurance, but in my estimation worth while as a means of helping genuine scholarship to begin to come into its own in the professions that deal with human behavior.

What can be done for children who are mentally retarded? The question is being urgently pressed today by parents who are not willing to assume the long-accustomed attitude that children thus disadvantaged should be hidden away in shame; and by others who believe that all children, even those whose capacities are extremely limited, should receive opportunities for achieving their maximum potentialities.

CHILDREN plans to explore this question in a series of articles in forthcoming issues by persons engaged in various aspects of work with mentally retarded children and their parents. Because an understanding of any problem is a prerequisite to an intelligent consideration of efforts toward its solution or alleviation, the series is being introduced with this article defining the phenomenon of mental retardation—insofar as it can be defined—and presenting its known and suspected causes.

FACTORS IN MENTAL RETARDATION

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VARIOUS SCIENCES have contributed to our present concept of mental deficiency. For a long time sociologists have observed that there are individuals who, since childhood, have been socially incompetent and incapable of adequate self-support. Psychologists, coming later, have noted that this social incompetence is often associated with defective intellectual development. They have discovered ways of measuring the degree of intellectual deficit and of establishing certain correlations between intellectual endowment and social attainments. Then as medical science advanced physicians became increasingly aware that some diseases occurring during fetal life or in infancy may result in lesions of the brain with consequent mental defect. Finally, with the advent of the science of human genetics the relevance of genetic factors in determining deviations of intelligence emerged.

Mental deficiency may be defined as a condition of arrest or incomplete mental development existing before adolescence, caused by disease or genetic constitution and resulting in social incompetence. This definition includes both the sociological concept which stresses the social inadequacy of the defective, and the psychological concept which is considered in the term "arrested" or "incomplete" mental development. The biological viewpoint is embodied in the mention of genetic factors and diseases.

Intellectual impairment developing after adolescence is not usually known as mental deficiency but as dementia, a customary differentiation for more than a century in both legal and medical thinking, in spite of its dubious validity.

Thus defined, mental deficiency is not a single condition, but a symptom common to diverse conditions of disparate etiologies and of various manifestations.

In the recognition of mental deficiency, the results of psychological examination play the leading role. The mental age (MA) is determined by psychometric tests and the intelligence quotient (IQ) calculated as

the rapport of the mental age to the chronological age (CA): $IQ=\frac{MA}{CA}100$. Other factors besides intelligence quotient are taken into consideration, such as educational attainment, emotional reactions, general behavior, and social adjustment. The information from both familial and personal history is carefully evaluated. Finally, a complete medical examination is performed, using modern techniques of clinical and laboratory medicine. It is upon the evidence thus collected that the diagnosis is made.

Considerable difficulty is often experienced in diagnosing the borderline cases between "subnormality" and mental deficiency. The criterion of social adjustment is decisive in these instances.

Incidence and Classification

In estimating the incidence of mental deficiency, a great deal depends upon the criteria of diagnosis used in the assessment of defective individuals. For instance, if the criterion of social incompetence is adhered to, the incidence will be higher in a strongly competitive urban environment than in rural communities. If a purely psychological criterion is adopted, the test used and the arbitrary point of demarcation between the defective and the nondefective individual will determine to a large extent percentage figures. If one accepts an IQ of 75 instead of one of 70 as the lower limit for the nondefective, the percentage of defective population will be over twice as large. Estimates based on institutional censuses are obviously inadequate and always too low, since only a fraction of the mentally defective population is institutionalized. Those based on large-group testing of school children have their limitations and are perhaps too high. Accurate surveys using modern techniques of securing data and uniform criteria of evaluating intellectual and social development have been few in number and limited in extension.

On the basis of scattered and incomplete data collected from many sources, it may be assumed that the incidence of mental deficiency in the general population is around 1 percent, using IQ below 70 as the criterion. This figure yields a total of 1,500,000 mental defectives in the United States.

Defectives are usually classified into three groups—idiots, imbeciles, and morons, but the corresponding terms of low-grade, medium-grade, and high-grade defective are to be preferred. Defined in sociological terms and in the language of the English Mental Deficiency Act (1927), idiots are persons whose mental defectiveness is of such degree that they are unable to guard themselves against ordinary physical danger. Imbeciles are persons whose mental defectiveness, though less extreme than in idiots, still prevents them from managing themselves or their affairs, or, in the case of children, of being taught to do so. Morons are persons whose mental defectiveness, though not amounting to imbecility, is yet so pronounced that they require care, supervision, and control for their own protection or for the protection of others, or, in the case of children, appear to be permanently incapable of receiving proper benefit from instruction in ordinary schools.

In more precise psychological terms, an idiot is a person having a mental age of less than 3 years, or, if a child, an intelligence quotient of less than 20. An imbecile is a person having a mental age of 3 to 7 years, inclusive, or, if a child, an intelligence quotient from 20 to 49, inclusive. A moron is a person having a mental age of 8 to 11 or 12 years, or, if a child, an intelligence quotient from 50 to 70 (or 75).

Although of considerable value in dealing with practical problems of defectives, both sociological and psychological classifications present limitations, being purely descriptive in character. More comprehensive are medical classifications which follow mainly etiological criteria, grouping patients according to the cause of the defect. While this type of classification may offer considerable difficulty in individual cases, because of scanty and contradictory etiological data or the fact that more than one etiological factor may be responsible for the defect, it does bring about a better understanding of the problem in relation to preventive measures.

Etiologically, mental defect can be divided into two large groups—endogenous or primary, and exogenous or secondary. In the exogenous group the defect comes chiefly from environmental factors. This group can be subdivided into types according to the causative agent—infectious, traumatic, toxic, and endocrine. On the other hand, an endogenous defect is determined mainly by those hereditary factors known as genes. The group includes conditions due to the combined action of many genes each of which alone would have an insignificant effect, or to the action of a single dominant or recessive gene.

Hereditary Defects

Multiple genes. Mental defects determined by multiple genes are "undifferentiated" in that they carry no specific physical distinction and are "aclinical" in that they show no clinical manifestations

other than intellectual impairment. This group has also been designated by other terms: "residual" because it is composed of individuals who are left after a classification of specific forms; "subcultural" because so many of its members originate from low cultural environments; "familial" because of the high frequency of the condition in the patients' families. Since these cases can be diagnosed only by psychological and social adjustment criteria, differentiation between high-grade morons and dull-normal individuals may be difficult. While antisocial behavior and psychopathic traits occur in the group, they are far from universal.

Estimates of the incidence of undifferentiated mental defects run between 30 and 75 percent of all the mentally retarded, the lower figure probably running nearer to the facts. It includes defects of all grades, but high-grade morons predominate.

While the etiological factors determining the large number of undifferentiated cases of mental deficiency are still in dispute, it seems likely that they are similar to the factors responsible for general intelligence—in other words, genetic constitution. It seems reasonable to assume that most of these undifferentiated cases represent merely the lower part of the normal frequency-distribution curve of intelligence, known to statisticians as the Gaussian form. This means that a certain number of individuals are bound to appear in the range below the line indicating IQ 70. They are an integral part of the population as a whole, just as are individuals with superior intelligence with an IQ above 130. According to the curve, the majority of undifferentiated defectives are in the moron classification with IQ's between 50 and 70, and only a very few at the idiot level, with IQ's below 20—a picture which corresponds to observed fact.

Genetic constitution, however, is not the only source of all undifferentiated defectiveness, for environmental factors, such as subcultural milieu and poor hygienic conditions, undoubtedly play a causative role. The task of tracing the source of the defectiveness in individual cases is not easy, particularly when malnutrition and deprivation have been in the picture.

Single genes. Some differentiated defects are determined by the presence of a single dominant gene transmitted from parent to child. Such defects are always traceable in the family history unless of a type that prevents reproduction. Frequently they turn up in severe form in alternate generations occurring in the intermediate generation only in incomplete form. Sporadic occurrences in families with no history of the defect are probably caused by a new mutation in a parental germ cell.

Data collected at Letchworth Village indicates that dominant genes probably account for only about 1 or 2 percent of all mental defects. These are always characterized by some physiological changes which make them classifiable into specific or clinically recognizable diseases. Among them are tuberosclerosis, neurofibromatosis, and nevoid idiocy—diseases in which mental deficiency is accompanied by skin lesions—and several forms of mental defect characterized by changes of bone structures.

There are also clinically recognizable defects caused by the presence of two similar genes, known as recessive genes, one from each parent. Since persons of blood relationship are more likely to carry similar genes, such defects occur more frequently among the offspring of consanguineous marriages than in the general population.

In the great majority of the recessive cases the parents themselves are normal, being merely carriers of the gene, or, in genetic terms, heterozygous for the gene. The defect is characteristically distributed among 25 percent of the sibs, and is sharply distinguishable. While such defects are on the whole rare, they include a number of specific diseases: amaurotic family idiocy, a progressive and fatal disease accompanied by blindness which, according to type, may show up in infancy, childhood, or adolescence; gargoylism, a disease characterized by mental deficiency and grotesque bone changes; phenylpyruvic idiocy, the result of an inborn error in metabolism of an amino acid: hepatolenticular degeneration, a progressive form of mental deterioration caused by degeneration of nuclei at the base of the brain; and some forms of diffuse sclerosis, also a progressive disorder causing brain damage.

Environment-Produced Defects

A large but not yet clearly determined proportion of defectiveness comes from factors outside the hereditary constitution including infections, trauma, poison, glandular disorders, and physical or emotional deprivation. Rough estimates, based on unpublished data from a number of institutions indicate that such factors may account for at least half of the mentally retarded population in the country.

Infection. Brain damage resulting from infection from the nervous system may occur in the womb or during infancy or childhood. The type of infectious agent, the severity of its attack, and the age of

the child when attacked determine the degree of damage.

One of the most prevalent of such infections used to be syphilis, transmitted during gestation from an infected mother through the placenta to the fetus and resulting in brain damage to the fetus and later mental defect in the child. While syphilis still is responsible for a small percentage of all defectiveness, the proportion of infected children has already been reduced by venereal-disease control programs and undoubtedly will be further reduced in the future. Especially effective has been the increasing adoption of routine serological tests of pregnant women, prescribed by law in many States.

One form of severe mental deficiency comes from rubella infection (German measles) in the mother during the first 3 months of pregnancy. Besides the intellectual impairment resulting from fetal brain damage the rubella virus's attack on the fetus often produces congenital deafness, anomalies of the heart and eyes, and microcephaly (undersized head and brain).

Facts about the effects of other virus infections of the mother on the fetus are not so definitely established. It is possible that some other viruses may act in a manner similar to that of the rubella virus.

Brain fever is estimated to be responsible for the mental defects of 10 to 20 percent of all institutionalized defectives, according to Letchworth Village data. Caused by one of the encephalitis viruses or by a bacteria, such as the meningococcus of meningitis, it often strikes in infancy and childhood. While many children recover from it completely and others die, some recover with permanent impairments, the most common of which is mental defect. Measles, scarlet fever, chickenpox, whooping cough, influenza, and other communicable diseases common in childhood also occasionally leave brain damage.

Patients whose mental defectiveness has resulted from acute attacks of these diseases are usually referred to as post-encephalitics. The degree of mental defect among them varies considerably with the individuals. Many of them exhibit a peculiar behavior pattern marked by episodes of overactivity, restlessness, impulsiveness, assaultiveness, and wanton destruction.

Trauma. While accidents resulting in injury to the brain may sometimes occur in infancy or early childhood they are insignificant in comparison to injuries at birth or in the neonatal period as a cause of mental defect. Cerebral trauma during birth has been variously estimated to cause from 10 to 50 percent of all defectiveness. However, the incidence in institutionalized defectives does not seem to be above 20 percent. According to data gathered by the United Cerebral Palsy from one-half to two-thirds of the children in the general population showing evidence of birth injury are not mentally defective.

Difficult labor and prematurity are the most frequent causes of brain damage during birth, the former because of the risk of mechanical injury and the latter because of the immaturity of the brain. An immature brain is more prone to damage.

Brain damage at birth comes either by asphyxia or by hemorrhage. Asphyxia, which must be present for a relatively long period to produce irreversible damage, may result from premature separation of the placenta, cord complication, overdosage of the mother with analgesic drugs, or delayed breathing by the newborn. Hemorrhage, which may be within the brain or its envelopes, comes from direct injury during delivery—by forceps, or by a tearing of the tentorium, one of the membranes of the brain, in compression of the head during its passage through the pelvic canal.

Toxic causes. Little is known about the effects of toxic factors transmitted from mother to fetus during pregnancy, but evidence exists for suspicion that there are several ways in which fetal poisoning, resulting in malformation and mental defectiveness, may occur. Eclampsia, a severe intoxication of obscure origin suffered by some pregnant and delivering women, may affect the child detrimentally. Some toxic drugs taken by a pregnant woman may also damage the fetus but what these are and how great the dosage must be to be damaging are still mysteries.

X-rays, on the other hand, are definitely known to be damaging to the developing central nervous system. Several cases are on record of mothers who after receiving deep X-ray therapy to the abdominal region during pregnancy have produced microcephalic children or children with other congenital abnormalities, including mental defect. However, improved knowledge of the effects of X-rays has resulted in the routine testing of women of childbearing age for pregnancy before radiation, and thus in the reduction of defects from this cause.

Blood incompatibility between mother and child also has a toxic effect upon the child. This comes about most frequently as a result of the Rh factor, an entity present in the blood of about 85 percent of the population, but absent in the other 15 percent. When an Rh negative mother (whose blood possesses

no Rh factor) carries an Rh positive baby, toxic substances develop which may cause damage to the fetal blood, liver, and brain. However, this condition is responsible for less than 1 percent of low-grade spastic defectives, as fortunately only 5 percent of Rh-positive children of Rh-negative mothers develop the disease, while some who do develop it recover completely.

Mongolism, or mongoloid idiocy, a condition with a characteristic physical appearance, may also be toxic in origin, although little is definitely known about its etiology. Some authorities believe that the condition appears in the fetus before the third month of pregnancy as a consequence of a variety of toxic conditions inherent in the mother and associated with advanced age, endocrine disorders, or pathological lesions of the uterus. Mongoloids comprise about 5 to 10 percent of all defectives. Their IQ usually runs between 15 and 40. Because these children are prone to infection, they have a higher mortality rate than other defective children.

Endocrine disorders. While a certain percentage of mental defectives suffer from some glandular dysfunction, the proportion of defectiveness caused only by endocrine disorders is small. Cretinism is a form of mental defect definitely traceable to hypothyroidism or impaired function of the thyroid gland, either because of its lack of development or early destruction. This disease, which is also distinguishable by physical appearance, is endemic in areas where goiter is also prevalent, but it also occurs sporadically elsewhere. Dysfunction of the pituitary gland also causes mental defect, the most common type, Frölich's syndrome, being characterized by obesity, underdeveloped genitalia, and mild intellectual impairment.

Deprivation. Emotional deprivation, frustrations, and insecurity may not only bring about a condition among normal children resembling mental defect but may cause incorrect estimate of the intellectual abilities of high-grade defectives, especially those also physically handicapped. Pseudo-feeblemindedness is produced in normal children so deprived by an emotional blocking which responds to psychiatric treatment.

The most severe form of pseudo-feeblemindedness, infantile autism, is dramatic, if rare, evidence of the importance of emotional factors in the development of intelligence. Children so affected behave like idiots, do not talk, respond to stimuli, nor engage in any activity requiring intelligence, even though their intellectual capacity may be normal or better than average. Psychiatric examination shows that their apparent defect is a form of withdrawal.

The classical case of Kaspar Hauser exemplified the degree to which deprivation of the means of learning could impair intellectual development. Such extreme cases are not likely to occur today. Nevertheless, deprivation of cultural stimulation in some isolated communities still plays a role in producing the apparent low level of intelligence among the populace. More tragic are the effects of such deprivation on patients with disabilities interfering with academic learning. False diagnoses of feeblemindedness too often occur among children whose only impairments are in hearing, reading ability, word comprehension, minor motor handicaps, or other disabilities. In these children emotional factors are undoubtedly also contributing to the picture of apparent intellectual defect.

The Individual

In spite of the growing knowledge of the causes of mental defects few specifics are available for their treatment or prevention. As the foregoing shows, mental retardation is not an entity itself, but a characteristic of a variety of conditions, each with a different cause. Moreover, in each form there is a wide range of intellectual ability.

Prevention for some forms may lie only within the scope of eugenic measures, though more scientific knowledge in the field of human genetics would be required before such could be confidently prescribed.

Greater possibilities for preventing the exogenous forms through medical and public-health measures may be expected to be realized as knowledge of intrauterine life and development increases.

While treatment in the strict medical sense can be applied only to a small number of mentally defective individuals, in the broader sense of care and training it can be applied to all. But such a wide variation of conditions exist among children with mental defects that what kind of care and treatment each receives must be determined individually in line with a prognosis based on an accurate diagnosis of the case. While the goal can rarely be cure, it can almost always be improvement or the achievement of the maximum intellectual and social functioning of which the individual is capable.

A new experience in public health . . .

THE POLIO VACCINE TRIAL

HART E. VAN RIPER, M. D.

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"NEVER BEFORE have I seen such cooperation. Every doctor, every nurse, every volunteer, was at the proper place at the proper time. I was just a bystander."

The man who spoke was a county health director in one of the 217 test areas in 44 States included in the polio-vaccine study of last spring. In minimizing his own efforts as the pivot of the operation in his county, he was expressing the gratification of a professional person who had witnessed for the first time the participation of numerous nonprofessional volunteers in a medical-research project.

The results of the nationwide vaccine validity test, involving records on 1,800,000 children, cannot be known until sometime in 1955. But apart from its medical implications, this huge study has written instructive chapters in the history of community action. While the actual conduct of the trial was under the jurisdiction of State and local health officers in cooperation with the National Foundation for Infantile Paralysis, the active cooperation of many people in many walks of life was essential to its success.

Briefly, the objective of the field trial was to determine to what extent the killed-virus vaccine, developed by Dr. Jonas E. Salk, National Foundation research grantee at the University of Pittsburgh, protects children from paralytic poliomyelitis under natural conditions of exposure. The vaccine's safety and its ability to produce specific polio antibodies in the blood had been demonstrated in extensive laboratory, animal, and human tests. But scientific advisers of the National Foundation for Infantile Paralysis decided that it could not be presented to physicians as a preventive agent against polio until its validity had been proved through field tests involving at least a half million children. The resultant field trial, largest of its kind ever conducted in this country, produced many lessons for the conduct of public-health programs.

First of these is that nowadays it need not take years for a new medical concept to be adopted. In a relatively short period of education, a great many people were willing to accept for their children a trial vaccine.

According to preliminary reports, 655,412 boys and girls, or 59.2 percent of those eligible for the test, reported for the first inoculation in the series of three. Although records are not complete at this writing, apparently only an insignificant number of these failed to show up for their second and third "shots," 1 week and 4 weeks after the first.

Percentages of participation varied from a low of 33.6 in one county to well over 80 percent in several areas and a high of 98.2 in a single county. In areas where a thorough public-education program was carried out early, the number of children participating usually was high. While everyone had been exposed to reports in the news, radio, and television, face-to-face contacts at local meetings with doctors, school people, and National Foundation workers and trained volunteers "clinched the deal." Briefing sessions and special literature also helped, but no pressure was exerted.

Parents or guardians were required to sign a request form before their children could participate. Some parents were so anxious for their children to have the vaccine that when their physician concurred they did not even let illness interfere. Youngsters recovering from measles or mumps were brought to the door of the clinics for inoculation. In some places

Production of the Salk vaccine requires strict measures to safeguard it against pollution. Here, behind the forbidding sign, laboratory workers add polio virus to nutrient 199, a synthetic mixture composed of over 60 chemicals, in which the virus rapidly grows and multiplies.

vaccination teams were sent to hospitals to give injections to children who were patients there.

Among less educated groups the loss rate after the first inoculation was highest. Many of these were people who lived in remote places and were inactive in community life. Lesson number two for community programs is that more effective ways must be found to reach such groups.

Planning at the national level took place over a period of many months with the Vaccine Advisory Committee of the National Foundation and other NFIP medical committees, with committees of the Association of State and Territorial Health Officers, the Public Health Service and the Office of Education of the U. S. Department of Health, Education, and Welfare, medical societies, nursing associations, commercial laboratories that were to produce the vaccine, and other professional groups concerned. The testing of this new vaccine on a mass scale would not have been possible without the advice, support, and collaboration of the great majority of the Nation's leading medical, scientific, and health authorities.

The task of orienting parents and the community at large to the forthcoming trial began long before plans had jelled, even before the project was an absolute certainty. Detailed and authoritative material was distributed to the press as each step was taken. Leaders of national women's organizations and men's service clubs were asked to explain the field trial to their State and local affiliates and to enlist cooperation.

State health officers participated in picking the communities where the tests would be made. Selection was based on: polio incidence during the past 5 years among children in the 6-to-9 age group; size of population; local health resources for the conduct of the trial; and social, economic, and geographical factors. State health departments appoint their own vaccine advisory committees, while State and county medical societies were drawn into the planning. Doctors volunteered through their county medical societies to give the injections.

Each of the 217 areas of study was designated for one of two types of statistical control. In 126 of them, all children in the second grade of school were offered the polio vaccine, while children in the first and third grades served as the control groups. In the other 91 areas, involving about twice as many children, first-, second-, and third-grade school children were inoculated, but only half of them received the vaccine. The other half received a control solution, similarly packaged, but containing no vaccine. No one at the trial knew which fluid each child received. Blood samples were taken from approximately 2 percent of the children in both control areas, including some children in the control groups.

In the placebo-control areas the percentage of parental consent was lower. With only a 50–50 chance of their child receiving the real vaccine, parents were less eager to subject them to injections.

Interpretation

This system of scientific control presented a thorny problem of interpretation to the lay public. To lessen confusion and explain to each area its control system the Foundation issued a variety of materials. These included: an informational leaflet to accompany a special letter to parents, sent from the schools with the request form; a filmstrip with an accompanying Teacher's Guide, to acquaint children in the classroom with simple facts about vaccination; a filmstrip for adults. A third filmstrip and guide for the instruction of clinic recorders, prepared in an afterthought, was rushed out too late to do much good.

From these activities emerged another lesson: Educational tools must be completed early and an efficient system of distribution devised so that they will receive maximum use.

The experiment also confirmed the primary importance of face-to-face meetings with the public of

public-health officers, physicians, and volunteers in which questions can be answered directly and points of misunderstanding discussed.

In this project such meetings revealed that parents were predominantly concerned about the vaccine's safety. They had read that each batch of the vaccine had been triple-tested by the pharmaceutical manufacturers producing it, by the National Institutes of Health of the Public Health Service, and in Dr. Salk's laboratory. They had been assured by scientists that this meticulous testing and retesting had reduced the risk almost beyond calculation. They had been told that before the mass tests began, Dr. Salk had inoculated more than 5,000 children and adults in Pittsburgh without any harmful results. Yet, when medical skeptics in a few places questioned the vaccine's safety and when a radio and TV commentator spread a frightening and erroneous impression, they turned to their doctors and their community vaccine volunteer group for further reassurance.

Though many people did withdraw their children when the safety of the tests were challenged, wherever the local groups were accessible for prompt and frank answers, much of the doubt and uncertainty vanished. The press of the Nation did a splendid job of printing the facts about the vaccine's safety.

The original plan called for approximately 200 test areas. Eventually, 217 counties or parts of counties in 44 States were entered in the trial. In places where participation was withheld or withdrawn, the reasons were early polio incidence—the test could not be valid in places where polio was already occurring—or reluctance on the part of health officials or medical societies who still felt insecure about the vaccine. The spreading of rumors and erroneous information also had its effect. In a few smaller communities health officers felt they did not have the resources and facilities to handle the trial. In one instance, legal problems in connection with the liability of local health departments, doctors, nurses, and volunteers prevented participation, but such problems were successfully solved in all other selected areas.

After inoculation in a New York City school. Here as elsewhere the unpleasantness of the needle prick was dimmed by the sense of sharing in a common experience.

School Participation

The choice of schools—public, parochial, and private—for the location of inoculation clinics was the happiest of decisions. They provided the most feasible way not only of reaching thousands of children, but of making the experience easier for them. The vaccinations became a matter of school routine and the youngsters went through them together like little troopers. Schools took on a great deal more responsibility for the organization and direction of the clinics than had at first been expected. Superintendents, principals, school nurses, and teachers spent hours in rearranging schedules, setting up clinics, holding meetings, and superintending recordkeeping. They made this a "learning through doing" experience for both adults and primary-grade children. Altogether 14,000 public, private, and parochial schools participated.

The trial began on April 26. By early March National Foundation headquarters had compiled and issued to health officers a manual outlining in considerable detail the operating procedures which were to be followed in every community. This was followed up by 18 "Operational Memoranda" to cover the specific duties of health officers, school personnel, and the various volunteer chairmen. While there were some protests about the length and number of these detailed instructions, health officers were soon ordering the 58-page manual in quantity. The trial revealed that an operation of this sort cannot be spelled out too often, or in too many ways.

The trial also showed that even a national, uniformly planned, scientific test can provide a good deal of flexibility and room for initiative with States and localities. The overall plan called for a vaccine volunteers chairman in the locality to head up a group

of five chairmen of volunteer committees, covering: volunteer headquarters; transportation; public information; public education; school volunteers.

Keystones for the community organization and education were the National Foundation's local chapters and their numerous experienced volunteers. In most instances, these served as reservoirs of supplementary voluntary personnel for the local health officers. The presence of these permanent groups, part of the Foundation's network of 3,100 chapters made it possible to introduce a radically new procedure like the field trial on such short notice.

The variety of jobs carried out by volunteers included preparation and distribution of public information materials, clerical and telephone service, help in packing and repacking medical supplies, transportation of supplies, forms, or personnel to clinics or vaccination centers, recordkeeping and other duties in the clinic. In addition, the armbanded vaccine volunteers were instrumental in maintaining the level of attendance through the second and third inoculations by persistent followup of parents through "reminder" cards, telephone calls, or personal visits to homes.

In a few places professional people failed to use volunteers to capacity and called on their professional colleagues for jobs that could have been done by laymen. Usually where this occurred the National Foundation chapter was relatively weak or the professional people had not had much previous experience with volunteer service. In most places lay and professional groups combined their skills to a remarkable degree.

Volunteer Help

The volunteers' ingenuity in making this a festive occasion for the kiddies added some fun and frolic to the clinics' serious purpose. They gave children lollipops, cookies and lemonade, or ice-cream cones as rewards and helped teachers amuse them with songs and games while they waited in line for the needle's prick. In Texas some of the children who gave blood samples saw a free movie or had a ride on a fire truck. One town in Kentucky offered every child who gave blood a certificate of heroism, entitling him to one ice-cream cone at the corner store. Another community upped the bait to 10 cones. The awarding of Polio Pioneer cards and buttons to children who completed all three inoculations was the final pleasurable duty of men and women who had patiently performed more onerous tasks.

A nurse takes a sample of blood from a child before inoculation. The samples taken in the Pittsburgh preliminary tests showed that the vaccine increased the antibodies in the blood without ill effects to the child.

It was originally estimated that some 200,000 to 250,000 nonprofessional volunteer workers would be needed to supplement the services of approximately 14,000 school principals, 50,000 classroom teachers, 20,000 physicians, and 40,000 nurses. Probably many more volunteers than anticipated engaged in the work. The average over the country was 2 volunteers for every 5 youngsters in the test. In some instances, more volunteers turned up than needed, but it was easier to send some home to return another day than to try to fill a deficit by recruiting in the middle of the operation.

Wherever maximum community participation was secured, it had been preceded by joint planning meetings well in advance of the trial. The initial planning meeting, called by the health officers, included key professional and community leaders brought together to work out the administrative and medical aspects of the trial. Usually represented at this early stage—ideally 4 weeks before V (Vaccination) Day—were the local medical and pediatric societies, nursing council, schools, Government agencies, and the National Foundation chapter and local office.

A second type of community meeting brought together representatives of major community organizations: men's and women's service clubs, church groups, business and industry, and labor unions to present them with accurate information on the trials and to recruit volunteers for assignments.

Wherever this type meeting was omitted, preparations for the trial got off to rather a slow start.

Many other formal and informal meetings were held before the trial got under way, including parent's meetings at schools. A number of educational techniques were used on these occasions—speakers, films and filmstrips, question-and-answer panels, and group discussions.

Many briefing sessions also were necessary to explain and assign duties. Recordkeeping was a particularly knotty training problem. Volunteers were confronted with complicated and unfamiliar forms. The system of handling records on each child had to be followed rigidly, if there was to be any hope of the complete information and accuracy necessary to evaluation of the vaccine. The tardy filmstrip on recordkeeping was badly needed.

School nurses, teachers, and volunteers helped keep the records. Where there were enough recordkeepers sharing the work, all went well, but when one person tried to shoulder the detail alone, confusion and loss of time resulted.

After the clinics were closed, volunteers in many places rechecked the forms to spot any mistakes or omissions which could be rectified. Early reports from the team of evaluators at the University of Michigan indicate that they are satisfied with the records they are receiving.

Difficulties and Assets

Clinics that operated with ease and speed far outnumbered those in which difficulties arose. Representatives of the National Foundation staff, who moved from place to place, gave advice and help when the occasion demanded. If there had been more of these staff members available, and if they had gone into the field earlier, some of the deficiencies and errors might have been avoided.

Wherever a bad situation arose it was caused by a variety of circumstances: the trial got off to a late start; there was insufficient coordination between State and local health departments; health officials and doctors were not properly briefed; or instructions were not followed up by proper supervision. Communities which attempted to place direction in either doctors' or laymen's hands alone soon found themselves in trouble. Neither group could work without the other.

The psychological effect on the children was an early concern of the National Foundation. It was hoped that the stage could be set so that they might profit from a practical health lesson, and take pride in participating in an historic occasion, even though they naturally would not like being stuck with a needle.

As it turned out, the children proved to be willing and unusually cooperative participants when they had advance orientation for the inoculations. Difficulties arose, and fears became evident when they were not well enough prepared. Only in a few instances were tears caused by other factors. Children who had to wait in line too long, especially when they were anticipating blood sampling, built up fears and anxieties. As one youngster put it, "It wasn't the needle that hurt; it was thinking about it." But in most places, teachers and volunteers successfully distracted their attention.

Although most of the children first learned about the vaccine test at home, what happened in the classroom had a significant influence on their behavior while the inoculations were taking place. Teachers showed skill and imagination in interpreting a scientific subject in terms little children could understand. While some felt "the less said the better," the majority planned classroom discussions which were related to elementary health, social studies, and history. Many used the National Foundation's filmstrip, "Bob and Barbara," and some posted newspaper pictures of children who had taken part in Dr. Salk's early tests. They naturally related the polio vaccination to other protective shots the children had already received.

The idea of becoming "Polio Pioneers" soon caught on. Certainly the lollipops and other rewards helped. The fact that friends and classmates were all in this together was also a great incentive.

At the date of this writing—scarcely a month after the last school clinic—this unprecedented medical field study has not yet fallen entirely into perspective. The successes and failures stand out clearly, but the reverberations will teach more lessons as time goes on. Certainly, one principle has been thoroughly established—that nonprofessional volunteers can work side by side with the scientist. The trial has also demonstrated that communities can mobilize for the advancement of medical science as they can marshall their forces in time of war and disaster. Surely all this power and potential can be tapped again for the solution of other acute health problems.

An inter-Bureau committee probes the problems involved in . . .

SERVICES IN THE ADC PROGRAM

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AN INDIVIDUAL who has participated in a group process of thinking or action has difficulty communicating to others the flavor of the experience. It is hard to explain what happened in the course of the experience which brought about the conclusions and convictions which the group derived from it. One finds himself wishing that others could go through the same process. One asks, Would others come out at the same place we did and with the same conclusions?

This difficulty of communicating experience is now being faced by members of the working committee of the Bureau of Public Assistance and the Children's Bureau who for many months jointly considered various aspects of the Aid to Dependent Children program in some detail. Therefore, in attempting to present the highlights of committee activity, we as committee members want to emphasize our feeling that the process we went through was of equal importance with the conclusions we reached. Or, to put it another way, to reach any conclusions with which committee members could find intellectual compatibility, we had to seek the answers to a number of fundamental and interrelated questions. Search for such answers put many demands upon all members of the committee in a variety of ways. It imposed the need to rise above our respective programs, to observe the disciplines of our professional knowledge, and to realize many times that the meaning of words is not in the words themselves but in us.

The reader will want to know how and why this working committee came into existence. For a period of time prior to creation of the committee, public reaction to the ADC program indicated some dissatisfactions with the program. While reactions varied from State to State and within States, public concern was being expressed in many places about behavior of mothers receiving ADC grants which did not seem consistent with the standards the community held for the sound rearing of children. Question was also raised over whether parents were being encouraged to elude their parental responsibility.

In many instances it was hard to identify the origin of this public reaction or to determine the measure of its validity. Nevertheless the Commissioner for Social Security felt that it was important to mobilize the resources of the Social Security Administration, Department of Health, Education, and Welfare, in such a way as to insure maximum help to States in their administration of this federally aided program. Therefore a working committee was appointed composed of representatives from the Children's Bureau and the Bureau of Public Assistance. The broad charge to the committee was to consider services to children in ADC families and ways in which the cooperative activities of the two Bureaus could help in the development of more adequate services.

The committee was able to identify in logical sequence the major questions which it was going to

COMMITTEE MEMBERS

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have to answer for itself in attempting to carry out this charge. In essence these were:

What is the purpose and nature of the ADC program?
What kind of problems are faced by families receiving ADC?
What services are required to meet these problems?
What knowledges and skills are needed to provide these services?
What are the services appropriate to the ADC program?
What contribution can the child-welfare program make to the services needed?
What are present realities and how can they be reconciled with desirable goals?

The consideration of these questions raised other issues that could not be resolved without considerable struggle. Voluminous papers were written and cast aside. Many trails were retraced. Many differences of opinion had to be reconciled. Of major assistance to the committee through all this process was source material from the experiences of staff in the field of practice, from published and unpublished writings on various aspects of the ADC program, from policy material of the Bureau of Public Assistance, from Congressional reports, and from the Social Security Act. The committee also developed rather detailed working papers to clarify for itself the quality of casework services that would be required to meet the needs of some of the families receiving ADC.

Necessary Review

We began by examining the Social Security Act and Congressional Committee hearings and reports. From this we established that the core factor in eligibility for the program is financial need and that the way into the program was through doorways of family disruption—death or incapacity of a parent, divorce, or desertion. In other words, we found that this was not a pension or insurance program nor was it one where financial need had been occasioned merely by unemployment.

The purpose of the program as set forth in the Bureau of Public Assistance Handbook indicated that it was a program for the preservation of family life in which children would be afforded the opportunity to grow up in a setting of their own family relations and have an equal opportunity with all other children to realize their capacities and share in the life of the community.

From this knowledge of the purpose and the nature of the program it became apparent that the families receiving ADC might be expected to have a variety of problems with which they would need help if the purpose of the program were to be realized. The committee recognized that while many families applying for ADC were quite adequate, the fact of dependency alone was productive of problems for them, particularly since financial need was also accompanied by the loss or disability of one parent. In addition to their feelings about dependency, these families were faced with such other major problems as readjustments in their standards of living, loneliness for the parent who was gone, and the need of the remaining parent to be both mother and father.

The committee further recognized that some families had difficulties beyond the immediate problems which brought them to the agency. Often the circumstances resulting in desertion and divorce arose from profound and prolonged parental discord and personal inadequacy which had left its mark on the children and had produced adverse family and community relationships.

What then were the services needed? The committee found that, first and foremost, adequate financial assistance was essential since inadequate clothing and shelter and lack of enough to eat would impair social as well as physical functioning to such a degree that unless these basic needs were met the families could not deal effectively with other problems they might have.

But was the provision of money enough?

This question posed a basic and major issue to the committee. If provision of adequate financial aid was not enough, was there a responsibility within the ADC program to provide other needed services? In terms of present realities and the foreseeable future, could staff within the public-assistance program be equipped to provide the skilled services needed by some families receiving ADC? Should the ADC program limit itself to establishment of eligibility and provision of money payments and seek other service when required from other community resources? Did the Federal act include in ADC the responsibility for social services?

This forced us to retrace our steps and look again at the Federal act, Congressional Committee hearings, and at the policy statements previously issued by the Bureau of Public Assistance. We had to look again at the eligibility requirements for ADC and what these requirements meant in the lives of individuals seeking this aid. Each of us brought to the discussion about this issue our own ideas and feelings that grew out of our individual experiences or lack of experiences with the ADC program. We had to struggle with these points of view until we were able to rise above "program mindedness" and look objectively at the parents and children being served

through ADC and how this could be a constructive experience for them. We did not resolve all of the basic issues, but we did come out with certain conclusions that we all believed in and could support.

Some Conclusions

We recognized that the very factors that made families eligible for ADC were also sources of emotional feeling and family breakdown. In addition, economic dependence and the need to apply for financial assistance through ADC has social and emotional import. Eligibility could not be established without taking into account these emotional and social factors and without making judgments that require social-work knowledge and skills.

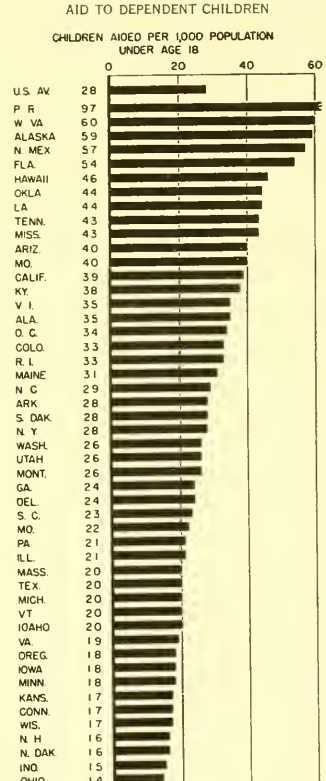
The committee believed that when the worker saw the applicant as a human being with feelings about the things that made it necessary for him to apply for ADC the worker could participate with him throughout the eligibility process with understanding, feeling, and respect for him as an individual. This would serve the applicant by helping him to evaluate and use financial and social resources he might not have recognized or made use of previously.

The committee concluded that the services in relation to initial and continuing eligibility should be available to all applicants and recipients in order to make the application for and receipt of assistance a constructive experience.

But what about the problems some people had beyond the immediate ones, which brought them to the agency? The committee recognized that these problems might often be complicated in nature, involving deep-seated emotional difficulties. However, we agreed that services needed and desired by these families should also be available if the ADC program were to achieve its fullest objectives—if the mothers of whom the community was critical were going to be helped to be good mothers and if wayward parents were to be helped to assume their proper responsibilities. It was our conviction that the needs of such families could not be met except by skilled casework help which, if it were not available in the public-assistance agency, would need to be sought from other sources in the community.

At this point the committee moved from talking about "services" to considering directly the skills and knowledges involved in providing them. After prolonged and careful consideration we became convinced that the purpose for which ADC was established and the eligibility requirements made it a program which required social-work knowledge, skills, and judgment. We believed that the use of staff without social-work education did not negate this fact. Family problems are no less real in areas where no social agencies exist, just as a person is no less sick because no doctor is available to care for him. The problem is—what to do about it?

Having reached this conclusion we had to widen our considerations beyond the worker and client to the setting in which they met. If ADC was a social-service program what significance did this have in terms of administration? The program, we agreed, must be administratively geared to its purpose and intent. This we thought meant conviction within the administration of the program that the public-assistance agency had administrative responsibility



for planning to meet those social-service needs that are related to the purposes of ADC. Administrative acceptance of this responsibility would be expressed through agency philosophy and administrative planning and would involve such aspects of administration as: suitable qualifications for staff; reasonable size of supervisory and worker loads; policies and procedures which were clear, consistent with each other, and related to purpose; and knowledge of and plans for use of community resources to meet families' needs which the public assistance agency itself could not meet.

Practical Steps

At this stage of developments the committee had the discouraging experience, not uncommon to social theorists, of having their deliberations received with something less than enthusiasm. The committee had been following the practice of clearing its conclusions with a wider group at intervals for reaction and perspective. Why, we were asked at this point, are you being so impractical and visionary? Where will you find the staff or community resources to provide all the services you have in mind? What States really need is help here and now with their day-to-day problems in administration.

The committee was not as unmindful of the "here and now" as it might have appeared. It recognized that, throughout the country, ADC staffs were in large part professionally untrained, sometimes supervised by others also professionally untrained and often carrying sizable caseloads. The committee was aware also that State public-assistance agencies varied widely in their concepts of the ADC program and in what they considered to be the scope of their responsibilities.

We felt, however, that a committee approach which was limited only to what States could accomplish at the present time would inevitably be a piecemeal and ineffective effort. We believed that what was needed were goals to which accomplishments could be related. Furthermore, in order for goals to have validity they would have to grow out of the legal base and purpose of the program. We realized that requirements for accomplishment were conditioned by the nature of the task to be performed as well as by the tools available for immediate use. We recognized that our dilemma in this respect was not unique since any enterprise which involves growth and improvement has objectives which may take some time to attain but which nevertheless serve as a blueprint for what is done on a day-by-day basis. Our confidence in our conclusions derived from the fact that the goals, as we saw them, were predicated not only on the legal base and purpose of the ADC program but also on what the field of social work had demonstrated could be accomplished for families with needs characteristic of those receiving ADC.

The next practical step for the committee to take seemed to be to consider how States might be given help in using the resources they now had available to move towards the goals we had thus far developed. This could take several forms. Our general thinking in this regard is perhaps best expressed by quoting an excerpt from the committee's draft report:

> ". . . Nevertheless such an application of principle to reality will give guidance to State public-assistance administration in policy formulation, in personnel planning, in determining the focus of staff-training activities, in the planned cooperative relationships which need to be developed with other programs and the lacks which need to be emphasized and stimulating community action.
>
> "Such an evaluation of the ADC program will bring to light strengths as well as weaknesses. It will suggest ways that staff can be, and are being, helpful to people even though skilled services directly related to a given need are not available in the community."

Throughout our considerations the question of what could be expected of "untrained staff" in the ADC program was ever present. This seemed a problem well worth attention since progress in the ADC program would depend largely on the staff now working in States many of whom did not have professional training. Based in part on our knowledge of already demonstrated performance of staff in many States, we concluded that workers with certain basic educational and personal qualifications could acquire on the job enough understanding and competence to provide the services we saw as necessary to the eligibility process and could therefore make the provision of financial assistance a constructive experience. We felt that staff so equipped would be able to help families with concrete, tangible aspects of living so that positive changes would emerge in feelings and relationships within the family and in attitudes towards self and others.

We concluded, however, that a requisite to on-the-job acquisition of such competence was supervision from persons with professional social-work education and experience and a well-planned staff-development program integrated with administration.

The committee recognized that there are limits to how far staff lacking social-work education could be expected to go in providing casework services even under adequate supervision. We saw a need for more information gained through controlled experiments to determine more adequately what might be

expected of staff without social-work education, but with competent supervision, in providing casework services.

At long last, but equipped with the knowledge and perspective which our detailed study of the ADC program had given us, we felt ready to deal with that part of the Commissioner's charge to the committee relating to the question: How the cooperative activities of the Children's Bureau and the Bureau of Public Assistance could help States in the development of more adequate services to ADC families.

The committee was then forced to look objectively at the child-welfare-services program for which the States receive some aid under Title V of the Social Security Act. We recognize that child-welfare services were not available in all local communities throughout the country and that in some communities child-welfare workers lacked social-work education and experience and were no better equipped to provide skilled casework services than were the ADC workers with similar professional lacks. The limited staff available in both programs emphasized the importance of making maximum use of all the technical knowledge and skills both within the agency and from other community resources.

We completely agreed that both the ADC and child-welfare programs had mutual concern that social services be available when needed by families and children. We recognized that each program had its distinctive purpose and function and that cooperative relationships should further the purposes of both programs. We saw the contribution of the child-welfare program to the State public-assistance program taking place in a number of broad areas:

Joint planning between the two programs in orientation and continuing inservice training.

Cooperative planning between the field staff of both programs in carrying out their responsibility to local units.

Cooperative efforts in community planning in order to develop needed services and facilities for families and children.

Consultation from child welfare to the ADC program for the purpose of strengthening administrative, supervisory, and casework staff at State and local levels.

Cooperative handling of ADC cases in which the services of child welfare are needed.

The effectiveness of cooperative planning, we believed, depended upon its beginning in the States.

Eventually we reached a point where we felt it would be unproductive to work longer without sharing the results of our deliberations with staff actively engaged in the administration of the ADC and child-welfare programs. Accordingly a "draft committee report" was prepared and was sent out to the States. Currently regional Public Assistance and Children's Bureau staffs are making joint plans for discussions of the report in meetings with the State agencies. From such discussions the committee hopes to test the soundness of the concepts it has developed and to discover if there are important aspects of the ADC program which it has not yet taken into account. An equally important purpose of the Federal-State discussions is to share with State administration the process which the committee went through in reaching the concepts and conclusions in the draft report.

The committee is not sure it has come to grips with all the issues which must be faced in the administration of the ADC program, nor that all of its conclusions are unassailable. However, we do have considerable conviction about the process which is involved and the steps which must be taken in reaching sound conclusions about services in the ADC program.

While we believe that the content of the report will be useful to States, the degree of its usefulness will depend in large part upon each State public-welfare agency asking itself the same sort of questions which the committee explored nationally: What is the legal base and purpose of the ADC program in our State? What are the needs of people receiving ADC? What services are required to meet these needs? What resources do we have here and how to provide these services? What should be our plans for the future?

THE ADC PICTURE

Recipients and grants, July 1954

Families receiving ADC	581,179
Children receiving ADC	1,565,887
Average monthly grant per family (3.6 persons per family)	$85.26
Total monthly expenditures for assistance payments (from Federal, State, and local funds)	$49,550,875

Staff members in social-work positions

Since most members of social-work staff in public-assistance agencies work on a variety of programs, the exact number involved in the ADC program is not known. However, on the basis of time studies made by persons with undifferentiated caseloads, it has been estimated that an equivalent of 8,500 to 9,000 executives, supervisors, and visitors were working on ADC programs as of June 1954. Of the total public-assistance social-work staff of 30,000 in 1950, approximately 11 percent had had a year or more of graduate social-work training.

Emotional as well as physical needs concern . . .

THE NURSE IN THE CHILD-HEALTH CONFERENCE

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THE ROLE of the public-health nurse in the child-health conference has become steadily more challenging, interesting, and complex. In recent years the knowledge about how children normally grow, emotionally as well as physically, has steadily increased, and clues for recognizing danger signals in this normal growth process have been established. Emphases in health-department programs on accident prevention, early detection of mental retardation, hearing loss, and dental defects all find a natural focus in the child-health conference. The immunization program, an important part of the clinic, in many official agencies poses an almost overwhelming task for the public-health nurse, because of the number of patients involved. Along with these emphases has come a quickening of interest in the part that environmental and social factors have to play in normal growth and development.

Theresa Harder's article in the May-June issue of CHILDREN pointed up the role of the medical social worker in the child-health conference, as carried out in the District of Columbia Clinic. That clinic is fortunate to have the services of medical social workers who give direct services. This is not available for most clinics in the country, and in the absence of such a service the initiative of the public-health nurse is required to find social casework resources in community social agencies.

Increasing Demands

Perhaps none of the activities of a well-child conference are new to all clinics, but even where many have long been established the pressure on the clinic to intensify its activities increases as more people become cognizant of children's needs. Through in-service programs and advanced educational programs, public-health nurses are preparing themselves to meet more exacting demands for good child health care and are trying to apply new knowledge.

The public-health nurse in the child-health conference has a variety of functions. What these are, of course, depends upon the objectives, facilities, and personnel of each particular clinic. If administration stresses quantity of immunizations as a criterion of good clinic care, the public-health nurse, unless she is careful, may find herself unconsciously case finding and home visiting with this objective foremost. On the other hand, if the clinician is a pediatrician who is aware of the emotional as well as the physical development of the child, the public-health nurse can assume a different counseling role than she can under a doctor oriented only to the physical aspects of child development. If her agency encourages the use of volunteers, she will have more time for group teaching and observation of the individual needs of the mothers and children who go through the clinic. If she works in a rural area confronted by transportation difficulties and with few, if any, social-agency resources or special consultants available her emphasis will have to vary, according to what can best meet the clinic's objectives. Whatever the limitations of the clinic, the nurse must keep herself informed of the basic patterns of normal growth and development as the child matures, and be aware of all the resources that can be called into play when she finds deviation.

In the majority of child-health conferences, the nurse carries out many kinds of activities. She sets

up and manages the clinic. She is its hostess, responsible for greeting and seating the mothers and making them comfortable while they are in the waiting room, and for establishing the warm friendly atmosphere which makes it easier for them to use the staff services. She interprets the clinic services and policies to new patients and takes their social histories. She also records pertinent information on returning patients to help the doctor in his evaluation. She weighs and measures children and takes their temperatures when necessary. In many clinics, she gives immunizations upon the doctor's standing orders.

Supplementing and coordinated with the doctor's interviews she also interviews the mothers individually according to their needs and helps them anticipate their child's next stage of development. When referral elsewhere for another service is indicated she is usually the one to interpret this need to the mother. If a social worker is part of the clinic team, the nurse supports both the patient and the social worker in the referral process. Her home visits are often planned on the observation of needs revealed in the behavior of the mother and child at the clinic.

The nurse also conducts informal group conferences of mothers, where she may show and discuss movies on growth, development, and child care if the clinic has sufficient space and staff to allow it. If the clinic uses volunteers, she is responsible for orienting and helping them.

Post-Clinic Conference

While the physician is the natural leader of the clinic team, at times the public-health nurse may initiate joint planning on the part of the doctor, the social worker, and the nursing group toward streamlining the child-health conference to fit present-day concepts of care or in evaluating the services offered. In many clinics she participates in postclinic conferences involving staff discussion and planning.

These conferences are becoming more and more prevalent as a means of bringing together the experience and observations of the staff members, making a plan for patient care, and assigning staff responsibility for carrying it out. Providing an opportunity for generalized observations on similar problems, the conferences might be considered a continuous method of evaluating to what degree the total staff is meeting its objectives.

Postclinic conferences are most prevalent in teaching clinics where they offer the student doctor or nurse an opportunity to discuss questions presented

One of the nurse's many duties in a well-child conference is to interview new patients, as in this picture, interpreting the clinic's services and recording pertinent information about the mother, the child, and the family.

by mothers at the clinic, as well as general questions regarding any aspect of child health. Problems of specific patients are discussed from the total-care viewpoint, with the doctor presenting his concern about the preventive medical aspects, and the nurse contributing information about the health, environmental, and social situations she has observed in her home visits and the results of direct nursing services and demonstrations. If a social worker is present she usually functions in a consultant capacity, although occasionally she may be contributing direct casework services to the family.

These discussions require all members to be aware of the effects of the mother-child relationship on growth and development. In the ensuing planning decisions are made as to whether the family requires more help from a doctor relationship, a nursing relationship, or a social-casework relationship.

The following case illustrates the nurse's role in carrying out plans made for one mother through a postclinic conference.

When Mrs. S. brought 6 weeks' old Jimmy to the clinic the first time, she had a drawn, worried expression. The nurse in taking the brief social history required for admittance asked the mother whether she had ever attended the clinic before. Mrs. S., the mother of three other children aged 21, 17, and 13, said she had attended so long ago she had forgotten just what the clinic was like. When the nurse remarked that Mrs. S. must feel as though she were having her first baby, the mother said that she felt

silly having a baby at her age, that she had thought she was going through the menopause when her pregnancy began and that she had felt embarrassed around the older children. To the nurse's comment that it must be hard for her, Mrs. S. replied that she didn't know how she would manage. Asked if her husband and children were helping with the baby's care, she laughed nervously and said that her husband seemed proud of having another baby and helped as much as he could. She was afraid the baby was being spoiled for he cried a great deal, was very active, and slept very little.

Mrs. S. said she found the baby irritated her though she knew it wasn't his fault. She also worried about whether she was feeding him too much because he seemed hungry all the time. The nurse assured her that the pediatrician would be able to help with the feeding and would be interested in all her concerns about the baby's care.

At the scales Mrs. S. held the baby away from her as if she didn't know what to do with him. She sat at a distance from the younger mothers while she waited her turn with the doctor. All this produced an impression of insecurity which the nurse summarized briefly for the doctor.

At the postclinic conference, the pediatrician expressed concern about this mother and her relationship to the baby—a healthy, alert, responsive infant. Mrs. S. had told the doctor she hadn't wanted another baby, because she was too old and too nervous. The nurse remarked about the mother's difficulty in holding the baby for its first immunization. Mrs. S. had cringed and had awkwardly jiggled the baby up and down instead of holding it close to her as most mothers do.

It was at this meeting that a plan was made for the staff to see this mother every 2 weeks in clinic until observations indicated that she was more secure in caring for the baby. The plan also allowed for frequent home visits by the nurse if Mrs. S. seemed to want additional reassurance or demonstrations in any phases of baby care that were troubling her.

A social-work consultant available to the clinic was asked to talk with Mrs. S. at her next clinic visit to help evaluate the situation and to determine whether referral to a social agency was called for. She decided against referral, but identified intrafamily relationships that aggravated the mother's need for reassurance in her care of the child.

The plan of frequent nursing visits to the home proved to be successful. The nurse followed up any cues to the mother's insecurity, watched her feed and bathe the baby, and commended her when appropriate. Beginning to gain confidence in her adequacy to care for the new baby, Mrs. S. became more relaxed in handling him, and as time went on complained less of his activity and her own nervousness. As her ability to handle the normal problems of child care became evident to the clinic staff, the home-nursing and clinic visits were gradually decreased. Anticipating that this mother would need additional help in handling the child when he became more mature, active, independent, and negative, the staff encouraged her to get ready for this stage by participating in informal group discussions with mothers whose children were presenting normal problems of independence as well as with those who had younger babies. The nurse stimulated these discussions while the mothers were waiting to see the doctor.

Mrs. S.'s baby developed rapidly and she spoke proudly of his appearance and accomplishments. Her case illustrates the help that can be given to a mother through joint staff planning. In the beginning and throughout the contact, the mother's feelings of inadequacy and hostility toward the baby were recognized and accepted. Through the reassurance she received, she could eventually accept herself and her role of mothering with more satisfaction.

Mothers' Needs

Informal group discussions for mothers conducted by the public-health nurse in the clinic setting are becoming recognized as a helpful educational medium. When the clinic uses volunteers for more routine tasks the nurse's time may be freed for this purpose. Whether it is feasible to hold them depends upon the public-health nurse staffing pattern, the space available, and the ability of the nurse to encourage mothers to find solutions to their own problems rather than to offer direct advice.

The presence of other mothers makes it easier to help the woman who says of her wiggling 2-year-old: "I wish he were a baby again. I get so mad at him when he won't mind and sit still." She will show obvious relief when other mothers in the group tell her that their 2-year-olds are just as difficult and that they are having the same problem. As the mothers begin to recognize a common pattern of 2-year-old behavior the nurse can back up their relief with the reassurance that while it is a difficult stage it is also a normal stage of development. Mothers need an opportunity to express their frequent fears that their children are developing differently than others.

Mothers can also learn a great deal from hearing other mothers talk about their difficulties in handling normal growth and development problems. Questions about thumbsucking, toilet training, feeding, weaning, and other problems are discussed enthusiastically if the atmosphere is conducive to free expression on the part of the women present.

Mothers' Needs

The public-health nurse can informally invite the mothers to participate in such groups. While the choice of subjects for discussion can be left to the mothers, it is usually helpful to start them out on something they have in common. For example: "Most of you have 2-year-olds. What are some of the things you've noticed that are different about the baby since he is older?" As one or two mothers begin to participate, the others feel free to bring up problems bothering them.

When the group is held to about 10 the nurse learns from listening what each mother needs to know about stages of her child's development and may pursue the subject with her later.

For example, one of a group of mothers told of her 2-year-old son's masturbation. "I slap him and slap him, but it doesn't help. What else can I do?"

The other mothers were very critical of her actions. At this point the nurse asked how *they* handled this problem, thus shifting the focus from the punitive mother. Recognizing, however, how deeply troubled she was, the nurse talked with her later in order to reassure her that a great many mothers were faced with this problem and to let her know that she could discuss it with the doctor. In the ensuing interview the doctor was able to go a little further into the causes of her concern and help her accept the behavior as a normal phase of development.

Health teaching cannot be effective unless it is based on the needs of the patient at the time the information is presented. For instance, the nurse's need to emphasize good nutrition may not be in keeping with the mother's readiness to learn what she has to offer. This was true of a young mother with her first baby, age 8 months, who interrupted the nurse's review of diet with "Oh, he eats everything I give him, but when will he get his first tooth?" Dietary instruction was obviously lost on this mother until her concern about teeth had been reduced.

Since counseling produces the best results *after* a mother expresses her needs by questions indicating her readiness for help, public-health nurses are handling fewer routine individual conferences.

Nevertheless, in home visiting or in the clinic, health teaching is one of the primary functions of the public-health nurse. In order to help mothers learn how to keep their babies and themselves healthy, it is necessary to know a good deal about their motivations and about their attitudes regarding health—to find out why each mother is attending the clinic rather than to assume she is there for the reasons the staff would like her to be. Some mothers think of the child-health conference as the place where their children get immunizations, and others as a place where they have opportunity for a little socializing. Many mothers come to the clinic to be told the baby is doing well rather than to learn to do things differently so the baby can do better. The nurse's ability to teach health knowledge will depend upon how well she accepts the patient's original motives for coming to the clinic and her ability gradually to develop a relationship with the mother that helps her to expand her use of the clinic and staff.

One way of evaluating a child-health conference is to count the mothers who do not keep appointments once the immunizations are finished. The fact that they drop out of clinic at that point indicates how little they feel the rest of the child-health conference holds for them. Although many of the behavior problems in preschool children occur as the child is striving to use his developing skills independently during the so-called training period, in many child-

In visits to the home, as below, the nurse observes whether the physical and emotional environment is conducive to the child's healthy growth and discusses aspects of child care about which the parents may ask for help.

health conferences children beyond the toddler stage are rarely seen. Similarly home visits by the nurse are usually more frequent on the infant level and unless something pathological occurs the mother is left to struggle with the preschool period on her own.

Another evaluation can be made by periodically reviewing the notations on the record to determine what the patient's problems are and what help they have been offered. Unfortunately these sometimes show a repetition of staff "advice" for a year without any analysis of why the mother has been unable or unwilling to follow the suggestions.

Careful thought needs to be given in planning priorities for making home visits. Most young mothers of first babies quickly learn a great deal through caring for their babies. They welcome the nurse's visits and are relieved to discuss at rather frequent intervals what they and their babies are doing. Mothers of first babies are particularly apt to need help in understanding how children develop during the "training age" from 1 to 3.

Emotional Problems

Through her work in the child-health conference the public-health nurse has some responsibility for the early recognition of emotional disorders. Through observation and listening to the mother's expression of concern about her child, she can become aware of each mother's major problems. She can not only recognize what kind of a mother-child relationship exists but help plan what approach can be used to help the mother solve the problems she faces in relation to her child's growth and development.

In talking with the mother the public-health nurse must be nonjudgmental and refrain from giving routine advice, while supporting the strengths she finds. If she believes that the mother's problems are primarily of an emotional or social nature, she brings this opinion back to the rest of the clinic team which may help her plan for referral to an appropriate community resource.

When a social or emotional problem calls for referral to a social agency the nurse's responsibility involves preparing the mother for referral. To do this she must know enough about the agency's policy to help the mother anticipate what her first visit will be like and what she can expect in the way of help. It is important for the nurse to have a way of exchanging information with the agency to help the caseworker understand why the child-health-conference personnel made the referral and what information the nurse needs to carry out her functions.

Unhappily, too many agencies still have no easily workable interagency plan for interchange of information between staff members working with the same family although conferences between nurse and social worker are desirable on original referrals and sometimes as casework progresses. The public-health nurse often knows a good deal about the family interrelationships, the living conditions, and the attitudes that play into the problem situation that could help the social worker. The two can work out together where nursing responsibility ends and casework takes over, although there will be some unavoidable overlapping.

Lack of time is usually given as a reason why such conferences are not arranged, though in the long run time will be saved if the two agencies work together. Confidentiality is another reason given for failure to exchange information. Here a mutual respect of each other's professional area of competence is required. The public-health nurse may need to take more initiative in asking for conferences with social-work agencies until these agencies recognize her interest and her potential contribution.

The long waiting lists for services in most social casework agencies require the public-health nurse to give support to the mother while she is waiting to be seen. In rural areas the lack of resources is a real barrier to the nurse's efforts to find family services based on skill outside of the field of nursing. Only too often she looks into every possible source of additional help to no avail.

Cooperation

The public-health nurse through her contact with rural or neighborhood doctors can do much to cement good relationships between the health department and the private practitioner. She is well aware of the role the family physician plays in giving care when the child or other member of the family becomes ill, for the child-health-conference staff refers mothers to private physicians when a question of pathology arises. It is reassuring to the mother to know that the public-health nurse and private physician keep informed of each other's activity.

Though public-health nurses are constantly looking for new ways to improve their services to mothers and babies, they cannot do this alone. Joint professional planning, including citizen participation in community efforts, is essential to the improvement of services in the maternal and child-health programs.

How big is the problem of juvenile delinquency? the answer requires the complicated task of . . .

COUNTING DELINQUENT CHILDREN

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JUVENILE DELINQUENCY has been defined as "any . . . juvenile misconduct as might be dealt with under the law."[1] Under this definition the term juvenile delinquency is obviously viewed as a legal concept. Other and possibly broader definitions based on psychological and social constructs have been advanced, and these may be appropriate for special purposes. But for purposes of general measurement, the legalistic, restricted definition seems most useful.

If modification in the definition is needed, it is surely in the direction of further clarification. Misconduct, like any other type of human behavior, can hardly be measured apart from the persons exhibiting the behavior. The question then arises as to whether it is the number of occurrences or experiences we wish to count or the persons involved. The point of view taken here is that the basic unit of count should be persons and that the descriptions of their behavior should be related, but corollary, counts.

In the United States, laws relating to juvenile delinquency are set forth in the statutes of the various States. State statutes define not only the term "juvenile" but also the term "misbehavior" or "delinquency." The definitions of juvenile delinquency as contained in State statutes vary widely and describe with varying degrees of specificity acts ranging from those that if committed by adults would be felonies or misdemeanors, through the types of behavior which have no exact parallel in the criminal codes and which are open to a high degree of subjective interpretation, such as "incorrigibility" or "ungovernable behavior."

An attempt to count children in relation to their delinquent behavior immediately introduces a time factor that resides implicitly or explicitly in all counts of juvenile delinquency. Assuming that a child becomes a juvenile delinquent when he first begins to engage in "such misbehavior as might be dealt with under the law," how long is he to be counted as a juvenile delinquent? Should he be counted only while engaged in the interdicted act, until he is no longer a juvenile, or at some intermediate point?

In community practice, juvenile delinquents are generally counted at a variety of intermediate points, as determined by the needs and procedures of the operating agencies that learn about and deal with delinquent children.

The magnitude of a juvenile delinquency count depends in large part on where and when the count is taken. The number of children known as delinquents to organized agencies is obviously smaller than the number of total delinquents by the very large proportions that are not detected and apprehended. Likewise, the number of children known to juvenile courts is less than that known to the police

[1] From Report of the Committee on the Socially Handicapped, *Delinquency*, 1930 White House Conference on Child Health and Protection, p. 23.

by those children who are released before or after arrest and whose cases are disposed of in some way other than referral to the juvenile court.

The calendar year has gained considerable acceptance as the conventional reporting period for juvenile-delinquency statistics. If comprehensive and unduplicated counts of children known to agencies at any time during the year are obtained, we have the basis of an "incidence" count.

To make comparisons between geographical areas or between different periods of time in a given geographical area it is highly desirable to compute rates. To compute rates we need denominators as well as numerators. The proper denominator is, of course, the population at risk of being delinquent. For a given jurisdiction the population of juvenile-court age may be used, but because this varies among jurisdictions when rates for more than one jurisdiction are to be computed, a convention must be adopted defining a uniform age group. The problem of computing rates is in practice complicated by the difficulty of obtaining population estimates for local units for intercensal periods.

Juvenile-delinquency statistics, derived as they are from agency records, cannot indicate the extent of hidden delinquency and, therefore, of total delinquency.

Moreover, such data are apt to reflect differences or changes in the operation of the recording agencies, as well as or even more than differences or changes in the phenomenon of juvenile delinquency itself. We must be sure of our numerators before we proceed to compute delinquency rates.

"Why Count?"

The purposes of collecting statistics on juvenile delinquency may be generally organized in three large, somewhat overlapping, categories.

1. Public information. The public is interested in knowing the extent of delinquency. Public interest in the statistics is apparently greatest in regard to trend or even of change from year to year. Is juvenile delinquency going down? But, especially, is it going up? If counts are rising, interest in the nature of the problem is likely to be heightened, resulting in increased demand for comparative data for local areas.

The motivation behind public interest may range from generalized concern, alarm, and fear to disciplined efforts to study, plan for, and bring about effective social action.

Operating agencies, such as the police, the juvenile courts, and training schools, may use delinquency statistics to stimulate public interest in their programs, in discharging their responsibilities for reporting on their stewardship, to justify their requested appropriations, and to point up need for extension and improvement of services.

2. Administrative statistics. In addition to their public-relations use, delinquency statistics have important potential applications to other administrative purposes, namely, in program planning, managerial control, and supervision. However, little has been attempted thus far in relating counts of delinquency to volume and kind of services and to costs of providing them. When this is done, analyses may be made of utilization of staff and other agency resources, and in assessment of agency organization and operating procedures.

3. Research. A completely satisfying evaluation of programs for the prevention, control, or treatment of juvenile delinquency can hardly be made without knowledge of the nature and types of delinquency and factors associated with its various manifestations. For more than two decades global statistics on juvenile delinquency derived from the police and the courts have been chief materials used in epidemiological-type studies whose purpose is to explore the social factors associated with juvenile delinquency. The fashion in recent years has been toward the more intensive clinical or microscopic research. In these studies social forces are also considered, to be sure, but additional and perhaps chief emphasis is on the psychological aspects. In any event, the number of variables introduced have become manifold, thus reducing the relative importance attached by some investigators to the basic count of juvenile delinquents.

The Conference on Control of Juvenile Delinquency, called by the Children's Bureau in April 1952, pointed out that general statistics could not "give an understanding of the problem of delinquency needed to plan practical services," because they do not "adequately discriminate between the great variety of personality and behavior problems requiring different approaches on the part of the people developing programs of prevention and treatment." But that conference did recognize the validity of operational statistics for administrative use and suggest ways in which research could improve their quantity and potential usefulness for program

evaluation. In fact, attempts at controlled and other clinical-type studies are frequently based on samples drawn from police or court statistics, and sometimes from institutions or other agencies. Whether or not the samples are useful for the problem under study depends to a large extent on the validity and the reliability of the population data from which they are drawn.

The objectives of juvenile-delinquency statistics are then to provide public information, administrative guidance, and a basis for research into the etiology of delinquency and into the administration of programs for treatment, prevention, and control.

How Are We Doing?

To what extent have the objectives of juvenile-delinquency statistics been achieved thus far? A description of the current scene may serve as background to a consideration of this question.

Police data. Since 1930, the Federal Bureau of Investigation has obtained reports from local and State police, both in summary form and in the form of individual fingerprint records. Until 1952 the individual fingerprint records were the only data collected nationally that described the social characteristics of persons arrested, that is, age, sex, and race. It was from the fingerprint card showing age of persons arrested that the FBI obtained its counts on juvenile delinquents and youthful offenders. Inasmuch as many communities, by law or practice, do not fingerprint children who are arrested, FBI statistics were far below the number of children actually arrested in the reporting communities.

In 1952, the FBI published for the first time data on age, sex, and race of persons arrested obtained from summary reports rather than from individual fingerprint arrest cards. These data are intended to represent all children arrested, whether or not they have been formally charged. In regard to these data the FBI states: "A number of departments whose reports were used in the tabulations volunteered the information that there were other agencies in the community which on occasions detained juveniles under circumstances amounting to technical arrest, which activity was not reflected in the police age, sex, and race of persons arrested report. Thus, it is quite probable the arrest figures herein presented, while far more complete than comparable data obtained from an examination of fingerprint arrest records are still conservative in the lower-age groups." [2]

Notwithstanding these limitations, it is clear that the discrepancy between the number of children arrested and those reported by a given community has been significantly reduced with the shift from fingerprint arrest cards to summary reporting of personal characteristics. Based on fingerprints and records the number of children under 18 reported as arrested in 1951 was about 37,000. The number in 1952 under the new summary reporting procedure was about 86,000—even though the 232 cities reporting that year represent only 15 percent of the Nation's population.

The increase in the number of children reported as arrested represents an important gain in the completeness of reporting by those police departments included in the FBI series. It is highly probable, but not certain, that this increase has resulted in a more accurate picture of arrests of children. Reports from local police departments through the FBI are on a voluntary basis. The data obtained represent neither a total count nor a sample of all cases, but rather an undetermined portion or "chunk" of the total.

The FBI publication *Uniform Crime Reports* shows that for 1953 the reporting areas cover about 42 percent of the urban population. While the report does not show the geographical distribution of the arrests, the FBI has made such information available to the Children's Bureau in a special tabulation. The data show that in comparison with the general coverage for the country as a whole, some regions are overrepresented while others are underrepresented. The Middle Atlantic States are rather seriously underrepresented, as are the Southern Central States. In terms of size of city, the FBI series is overrepresented for medium-sized cities and underrepresented for both very large and very small communities. The effect of this disproportionate coverage on the data reported cannot now be determined.

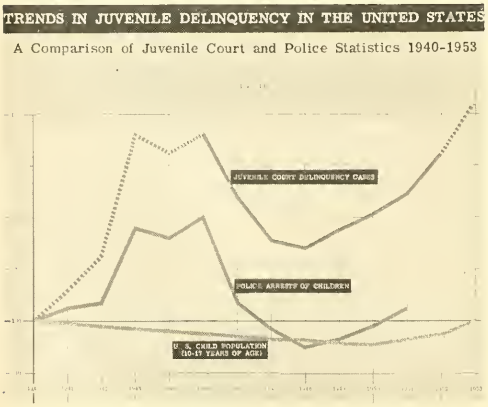
Juvenile-court reporting. The Children's Bureau has collected reports from juvenile courts since 1926. The method of collection in the early years was for each reporting court to send individual data cards to the Bureau on each delinquent child appearing before the court. Later the courts were asked to tabulate their own data and send their summary reports. In 1946 the Bureau adopted the policy of requesting the appropriate agency in each State to

[2] Uniform Crime Reports. Washington, D. C.: Federal Bureau of Investigation, vol. 23, no. 2, 1952.

act as a collection and summarizing agent. In 1952, in an effort to increase the number of reporting areas, and on the advice of the Children's Bureau Advisory Committee on Juvenile Court Statistics, the amount of detailed information requested was drastically reduced. Such items as age of child, reason for referral to the court, type of detention care, and disposition of case were eliminated. Attempts to obtain unduplicated counts of children known to courts were postponed. The reports now call only for information on the number of children brought before the court for reasons of delinquency, dependency, and neglect, whether handled officially or unofficially, and on sex of children in delinquency cases.

The number of courts reporting rose from 458 in 1951 to 586 in 1952. At the same time the proportion of the child population of the country 10–17 years of age covered by the series increased from 23 to 29 percent.

An important technical limitation on coverage in the Federal-State reporting series is the seeming inability of many courts to obtain counts in cases handled "unofficially," that is, by court personnel other than the judge. Because practices concerning selection of cases to be heard by the judge of a juvenile court vary widely from court to court and even within a given court over a period of time, the reporting of "official" cases only may be a misleading count. The present practice of the Children's Bureau is to include in the regular Federal-State reporting series the reports of only those courts that report both official and unofficial cases. However, the Bureau publishes special tables including the counts of courts whose reports are made up of official cases only.



The juvenile-court series shares with the police-arrest series the disability of not representing a definable sample. Like the Federal Bureau of Investigation series the Children's Bureau reports are overrepresented for some regions and underrepresented for others. For example, the Middle Atlantic, the Southern, and the Mountain States are all seriously underrepresented in the juvenile-court series. The series is also underrepresented in counties having less than 10,000 population.

The apparent bias on the geographic coverage of the juvenile-court series seems somewhat similar to, but not identical with, that in the police-arrest series. The correspondence in specific communities covered by both series is however quite low. For example, of the 106 largest cities in the country (over 100,000 population) only 25 are included in both the juvenile-court and police-arrest series. Of the remaining cities this size, 31 are reported only to the Federal Bureau of Investigation, 18 only to the Children's Bureau, and 32 to neither. Furthermore, the age and sex distribution of the children in the two series varies widely.

A noteworthy phenomenon is the way in which the two series move together from year to year. This can be seen on the chart "Trends in Juvenile Delinquency in the United States" (see chart). At no time for which we have data have they moved other than in the same direction. Among the possible explanations for this are the following:

1. The correspondence in the direction of change in the two series is fortuitous.

2. The correspondence is due to common determinants in the two series, but these determinants contain such systematic error that neither series has any meaningful relationship to actual changes in the phenomenon being measured.

3. The correspondence is due to common determinants in the two series and both series have a positive relationship to actual changes in the movement of juvenile delinquency in the United States.

The Bureau favors the third interpretation. The probability of fortuitous correspondence, the first interpretation, is so low as to rule it out of practical consideration. However, our choice between the second and third interpretations, that is, our feeling that the series reflects real change, is based only on our observations that the data seem to make some

sense. This subjective feeling is not, of course, good enough for meeting the purposes of juvenile-delinquency statistics. Moreover, as the chart indicates, there is no positive agreement on the magnitudes involved. Although we may place some reliance in the correctness with which the series indicates whether delinquency is increasing or decreasing, the data do not give any clear picture of the actual size of the problem at any one time or from year to year. The available national statistics on juvenile delinquency constitute, in effect, a measuring instrument somewhat like a weathervane, which shows the direction of the wind but not its velocity.

In the hope of obtaining a measure for the volume of juvenile delinquency, the Children's Bureau Advisory Committee on Juvenile Court Statistics recently recommended that consideration be given to establishment of a national sample of juvenile courts for reporting purposes. The establishment of a sample will have additional values. It should make possible speedier estimates than can otherwise be obtained. By focusing attention and assistance on the courts in the sample, it may be possible to elicit at intervals some of the desirable descriptive data that was abandoned in the interest of greater coverage in the total Federal-State recording system.

The proposal to establish a sample of courts contemplates that the regular Federal-State reporting system will also be maintained, because of the values to the States in becoming familiar with statewide information on juvenile delinquency.

The most important current development in the juvenile-court series is the work now in progress in designing, with the valuable assistance of the sampling experts of the Bureau of the Census, an efficient national sample of juvenile courts for statistical-reporting purposes.

Such a sample will make available reliable estimates of the size of the juvenile delinquency load in the courts of the United States. The sample will give appropriate consideration to courts in the different regions of the country and to courts in rural places as well as in larger towns and metropolitan areas. If the sample is to give results with a margin of error of say, less than 5 percent, on estimates of the total volume of delinquency known to courts, it will be necessary to include all of the largest courts in the country—that is, the 60 largest courts or all of those with jurisdictions of 50,000 children or more. Many of these courts and some of the courts which will be selected to represent the smaller places are not now currently in the Federal-State juvenile-court reporting system. Considering the size of the problem and resources available for the job, the Bureau expects to have the sample reporting system installed in preliminary form by 1956.

Other Statistics

The two other national collections of data pertaining to juvenile-delinquency statistics are those of the Bureau of Prisons of the Department of Justice on children charged with violation of Federal laws and data on children in training schools collected by the Bureau of the Census in 1950. The latter represents the first national census of the population of training schools for delinquent children since 1933, and makes possible some important measures of the changes in the 17 intervening years. The Children's Bureau has recently completed a special survey of the characteristics of these institutions.

A complete inventory of data on juvenile delinquency in States and in local communities is not yet available. Impressions gained from the operation of the juvenile-court series, some field consultation, and review of publications is of a slow and rather fitful growth in reporting coverage. A considerable amount of recent growth has apparently been stimulated by statewide agencies interested in youth and child welfare. The pioneering efforts in Ohio, Michigan, and Missouri toward complete statewide juvenile-court reporting have been emulated in a number of other States. Statewide juvenile-court systems in Connecticut, Rhode Island, and Utah have emphasized better statistical reporting.

A recent article in the *Journal of Criminal Law, Criminology, and Police Science*, entitled "An Accounting Plan for Juvenile Probation,"[3] describes an ambitious attempt to obtain complete and accurate reporting of probation services in California. The current experience of the New York City Youth Board in operating a register of delinquent children known to agencies is one of the more interesting local developments in juvenile-delinquency statistics.

States, and especially local communities, need and can use far more detailed information on juvenile delinquency than would be appropriate to gather nationally. The design of an efficient system for the reporting of juvenile delinquency in this country would provide a broad base of information in local communities with increasingly selective use of these data by State and National organizations.

[3] Volume 43, Number 6 (March-April 1953), pp. 705–718.

An essay-review . . .

UNDERSTANDING ADOLESCENTS

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GUIDING THE ADOLESCENT is at once an important and exceedingly complex task. Learning how to help children develop during the early years is important and complex too and one might expect that as they advance in age the task would become somewhat simpler. There are many reasons, however, why this does not happen. For instance, guiding the adolescent involves assisting him in making decisions about problems that baffle adults as well as teen-agers. We adults can reach considerable agreement as to how to help very young children adjust to the simple physical and social environment they face and we can keep our home and school environments under control so that these adjustments are well within the limits of the young child's abilities. But the adolescent is entering an uncertain, complicated, and troubled world. Helping him to understand the problems of achieving independence, engagement and marriage, finding a job, building a philosophy of life is as difficult as life itself.

The new booklet for parents entitled "The Adolescent in Your Family," [1] recognizes both the complexity and importance of guidance at the adolescent level. It brings together a variety of knowledge about development at this age and formulates suggestions as to how parents can assist the adolescent in adjusting to physical changes, assuming responsibility, achieving independence, developing constructive relations with peers, adjusting to the opposite sex, and planning the educational and vocational steps toward a happy and useful life.

Past literature on adolescence fails to bridge an apparent disjunction between research findings on the one hand and daily-life situations on the other. For example, the usual college textbook will present elaborate graphs showing how scores on an intelligence test will, on the average, increase with age throughout the teen years. But it never comes to grips with the problem of why in spite of this increase in intelligence some adolescents will show such "unintelligent" judgment as to drive 90 miles an hour through downtown traffic.

Similarly the usual text may go to great length to show how height, weight, chest girth, and size of ovaries and testicles change during the adolescent years, but will not tackle the problem of how the adolescent can adjust to the wide individual differences in the various aspects of physical growth. Studies of adolescent problems indicate that the physical and physiological changes in and of themselves do not cause difficulty, but rather the attitudes people take toward them. The usual text, however, fails to consider the origin of these attitudes or ways of overcoming them.

On the other hand, the text more than likely refers to a rapid increase in growth of the body in adolescence, ascribing to this the prevalent problem of awkwardness and thus overlooking available data which indicate that the various parts of the body do not all grow at the same rate nor do some individuals shoot up as suddenly as others. Such an assumption also ignores data suggesting that changes in scores on tests of motor coordination are not correlated with gains in height or weight. The usual discussion does not consider the question of why awkwardness should appear when scores on motor coordination tests do not decrease.

The new bulletin of the Children's Bureau represents a much more effective integration of research findings and the daily problems of adolescents than has been usual in the literature of the past. For example:

Boys and girls don't fall over their own feet, blush, and drop things because they are growing so fast or so unevenly. . . . lack of gain in coordination at this

time isn't because of physical growth; like other bodily functions, such gains have different rates of growth at different times. Any physical awkwardness when a young person is growing fast is likely to be associated with the new self-awareness. It is much more a matter of social awkwardness than of lack of skill in managing his body. Given a setting in which a boy is unself-conscious—when he's swimming or driving a hayrake for example—he has no trouble making his muscles work together. But if he can't have his clothes replaced as fast as he grows out of them, or if constant comments are made about his big feet, or long arms, he may feel awkward indeed in group situations.

Another problem of analysis and synthesis that has plagued the writers on human development has been the complexity of human behavior when they are faced with describing the difference between what children do, under various cultural conditions, and the meaning of the behavior for the individual. Literature for parents too often assumes or implies that what most adolescents are doing or do frequently is "normal." Thus there are tabulations of the frequency of conflicts with parents, the unrealities in vocational ambitions, the extent of masturbation, or avoidance of study of high-school mathematics. However, since the origins of any form of human behavior are complex, before we can approve, disapprove, condone, or condemn we have to know something about the underlying causes, about how the behavior pattern developed and what it means to the individual.

This booklet on adolescence represents a distinct step forward in emphasizing a more fundamental approach to behavior. For example, in regard to the use of money it says:

. . . Attitudes toward money are built up partly on the basis of emotional needs. When a boy or girl spends excessively or unwisely, hoards, or shows any other striking attitude toward money, parents might want to consider underlying causes. Why is it that one boy needs to impress his friends by picking up the check for a double-date stop for hot dogs? Why does he feel the need of this kind of recognition by his peers? Why does a certain girl cautiously cling to her money as though it were a life-preserver? What other way can be found of giving her the security she seems to find in being miserly?

The same emphasis on understanding what is behind behavior appears in the discussion of drinking:

If drinking threatens to become a problem, the concern of parents should be to discover why a young person needs the transient sense of well-being and the false sense of importance that alcohol lends . . . Anyone whose inhibitions are such that he must try to get rid of them to feel happy needs help. Such help can come only from people whose training has fitted them to unravel the causes of the fears and doubts the person has about himself . . .

Throughout, the bulletin stresses the influence of various environments—home, school, community—on the adolescent's development, an emphasis that has been affirmed by research findings during the last 15 years. It also refreshingly calls for recognition of the adolescent's ability to weigh the pro's and con's of his daily problems:

When we set down rules, they should be rules that our children shared in making. Our teen-agers are fully capable of thinking through such problems as hours for coming home at night, sharing the use of the family car, and other such questions. If rules are made only to bring peace of mind to ourselves, there is little incentive to live up to them.

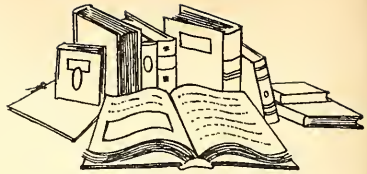
Thus, the bulletin will help parents appreciate that the adolescent can take part in building his own environment, that everything does not have to be done for him, that he can understand and take hold. The possibility of guiding the young person to learn more about his social environment, including the behavior of himself and others, has been encouraged by recent research. As a result, materials are now appearing designed to help adolescents gain more understanding of the forces that operate in human behavior. After parents have become thoroughly familiar with this possibility they may want to provide such materials for their teen-agers. Some of the recent pamphlets that have appeared in the Public Affairs series and in the Science Research Associates series may be of interest at this point. Other sources of this type of material are State departments of health, college and university extension divisions, and State mental-health societies.

In guiding the adolescent, as in guiding children of any age, the personal adjustment of the parent is an important prerequisite to success. Since problems at the teen-age level require much analysis and weighing of evidence, the emotional freedom to consider several sides of a question becomes doubly important in a parental discussion with an adolescent. Parents can obtain help from parent discussion groups and the extensive literature on personal adjustment that is now available.

Thus the new booklet, "The Adolescent In Your Family," finds a central place in starting the parent in his task of understanding and effective guidance.

[1] Children's Bureau, U. S. Department of Health, Education, and Welfare: The adolescent in your family. Pub. 347. Washington, D. C.: U. S. Government Printing Office, 1954. 114 pp. 25 cents.

BOOK NOTES



CHANGING CONCEPTS IN CHILD CARE; professional papers presented at the Jewish Child Care Association of New York, held at the New York Academy of Medicine, January 7, 1954. The Association, New York. 78 pp. $1.50.

"Today it is rare indeed that a child comes to us for placement only because the family or its remnants has no means of support," says the executive director of the Jewish Child Care Association of New York, describing changes in the association's practices over the past two decades. Pointing out that public programs such as Aid to Dependent Children and services such as family counseling have virtually eliminated the economic causes of removing children from their own homes, he defines present-day placement as "a protective service required by particular children under particular circumstances."

The book devotes a chapter to each of three types of foster care provided by this agency: Specialized foster-family care for emotionally disturbed children whose behavior could not be tolerated in ordinary foster homes; cottage-type institutional care for emotionally disturbed children; and institutional care for the mentally retarded.

NEW DIRECTIONS IN SOCIAL WORK. Edited by Cora Kasius. Harper & Bros., New York. 1954. 258 pp. $3.50.

A number of contributors to this symposium give their ideas on the present state of social work, each charting the course that he believes the profession should follow in the future. Among the subjects treated are the responsibilities of a socially oriented profession, the changing functions of the voluntary agency; guiding motives in social work; and the responsibility of government to promote the welfare of the people.

According to the editor, "the authors, looking at the field from various angles, seem to be in general agreement that the profession is in need of a basic overhauling."

The book was prepared as a tribute to Philip Klein on his retirement from the New York School of Social Work.

PARENT COOPERATIVE NURSERY SCHOOLS. Katharine Whiteside Taylor, Ed. D. Bureau of Publications, Teachers College, Columbia University, New York. 1954. 257 pp. $2.85.

In her preface, the author says that this book "makes no attempt to duplicate the excellent volumes on nursery-school techniques and procedures already available, but deals rather with the unique values and problems of parent cooperatives and the insights and processes found most helpful for their operation. It seeks to give parents the basic orientation that will make the contributions of other books and teachers more meaningful, and to give teachers suggestions that may be helpful in working with parents."

THE ENCYCLOPEDIA OF CHILD CARE AND GUIDANCE. Edited by Sidonie Matsner Gruenberg. Doubleday & Co., New York. 1016 pp. $7.50.

More than half this book is prepared in encyclopedia form, with the subjects alphabetized—from "Abilities" to "Youth organizations." Most of the remainder consists of articles, by different authors, on basic aspects of child development. Many additional sources of information are listed—public and private agencies, and books and pamphlets.

THE JUVENILE IN DELINQUENT SOCIETY. Milton L. Barron. Alfred A. Knopf, New York, 1954. 349 pp. $5.

In his preface the author says that the solution of the juvenile-delinquency problem, "like that of other social problems, depends on an orderly modification of the American social structure and some of the values and functions of American society." Part 1 defines the problem, offers statistics, and considers the dynamics of delinquency, with special reference to the business cycle and the cycle of war and peace. In part 2, which takes up the causes of delinquency, the author indicates as the key chapter the one titled "The Delinquent Culture of American Society." Part 3 discusses detection and detention, the juvenile court, and institutional and other treatment, and concludes with a chapter on programs and techniques for preventing and controlling delinquency. The book is designed primarily for use as a text in courses on delinquency and criminology.

JUVENILE OFFICER. Capt. Harold L. Stallings, with David Dressler. Thomas Y. Crowell Co., New York. $3. 1954. 247 pp. $3.

Through a series of case histories, Capt. Stallings, who is with the Los Angeles County Sheriff's Department, conveys an idea of the complexity of police work with juveniles. As for the background of delinquency, he considers the family the greatest influence for good or evil—"it makes delinquents and also makes wholesome children."

PEDIATRIC PROBLEMS IN CLINICAL PRACTICE; special medical and psychological aspects. Edited by H. Michal-Smith; with 14 contributors. Grune & Stratton, New York. 1954. 310 pp. $5.

According to Dr. Howard A. Rusk's introduction, this book is addressed "not only to pediatricians, but to all physicians, psychologists, social workers, and teachers concerned with the health and welfare of children." The chapters cover problems of the emotionally disturbed, the schizophrenic, the mentally retarded, the brain-injured, the cerebral-palsied, the orthopedically handicapped, the allergic, the cardiac, the diabetic, the epileptic, and the tuberculous. A chapter on the sick child and one on the normal child are also included.

PROJECTS AND PROGRESS

New Laws Affecting Children

Children are affected, directly or indirectly, by a number of laws passed by the 83d Congress, which adjourned August 20, 1954. These included, among others, measures affecting social-insurance benefits, juvenile delinquency, hospital construction, education, school lunches, and income-tax deductions.

Insurance. January 1, 1955, large numbers of children will be added to those already receiving protection against the death of their parent-breadwinner under the Social Security Act, since Congress amended the act to bring about 10 million more workers into coverage of the Old Age and Survivors Insurance program. The amended act also increases OASI benefit payments. For example, a child previously receiving an $18.80 monthly benefit will now receive $30 a month. (Public Law 761.)

Juvenile delinquency. In a move to combat juvenile delinquency Congress made a $75,000 supplementary appropriation to the Children's Bureau to assist States and communities in improving services and facilities for delinquent children. (Public Law 663.) It also directed the subcommittee on juvenile delinquency of the Senate Judiciary Committee, originally scheduled to end its work February 28, 1954, to continue until January 31, 1955; and provided an additional $175,000 for the committee's investigation. The committee's appropriation was $44,000.

Housing. The National Housing Act of 1954 (Public Law 560) authorizes 35,000 units of low-rent public housing in addition to those under existing contract. The law restricts the new units to communities that have active slum-clearance programs.

Safety. Public Law 385 makes it a Federal offense to "bootleg" fireworks into a State where they are illegal.

Indians. Administration of health services for Indians and the operation of Indian hospitals is transferred from the Bureau of Indian Affairs, Department of the Interior, to the Public Health Service, Department of Health, Education, and Welfare, by Public Law 568. The law permits such facilities to be transferred under certain conditions to State, local, or private agencies for operation.

Hospitals. Aid to the States for hospitals and health centers has been broadened by an amendment to the Hospital Survey and Construction Act of 1946 which provides funds for the construction of four types of facilities for the chronically ill and impaired. (Public Law 482.) The appropriation includes: $2 million to help the States survey needs and develop programs; $6½ million for diagnostic and treatment centers; $6½ million for additional hospitals for the chronically ill; $6½ million for rehabilitation centers; and $4 million for nursing homes.

School lunches. The Agricultural Act of 1954 authorizes the Commodity Credit Corporation to give surplus food commodities to nonprofit school-lunch programs. It also authorizes $50 million of Commodity Credit Corporation Funds to be used annually for the next 3 school years to serve milk to children in nonprofit schools of high-school grade and under. (Public Law 690.)

International programs. For international programs during the fiscal year 1955 which directly or indirectly affect children Congress appropriated the following: for the United Nations Children's Fund (UNICEF), $12,500,000; for United Nations technical assistance $9,957,621; for similar programs under the auspices of the Foreign Operations Administration of the United States Government $105,000,000.

Physically handicapped. Congress amended the Vocational Rehabilitation Act to expand the program, both financially and in kinds of services. By 1958 the program may involve $65 million in Federal funds, which may be distributed to the States on a variable grant basis. (Public Law 565.) Supplementary appropriations of $4 million for grants to the States and $900,000 for training personnel bring the program a total of $27,900,000 for the fiscal year 1955. (Public Law 663.) Of 56,000 people rehabilitated under this program in the last year 12,000 were under 21.

Education. Public Law 530 authorized a White House Conference on Education, to be preceded by State conferences. For this purpose, $900,000 was subsequently appropriated, of which $700,000 is to be allotted for the State conferences. Public Law 531 authorized the Commissioner of Education to arrange with educational institutions and agencies for a joint program of research in education. Public Law 532 authorized the Secretary of Health, Education, and Welfare to appoint a National Advisory Committee on Education.

Congress also extended for 2 years the time allowed under a previous law for use of Federal funds for school construction in communities near military reservations and other places affected by Federal installations (Public Law 731), but made no additional appropriation.

Tax exemptions. In the revised tax law (Public Law 591) changes in the definition of "dependents" for whom deductions of $600 each can be claimed enable parents to claim more deductions than under the former law. A son or daughter whose parent furnishes more than half his support is considered a dependent regardless of the child's earnings: if he is under 19 or if he is over 18 and is attending school or college or receiving on-the-farm training.

A working parent who is a widow or widower is allowed an additional deduction up to $600 for the expense of caring for each child not yet 12 years of age. Such a deduction is allowed also to a mother who must work because her husband is incapacitated, or to a married couple whose combined income does not exceed $5,100.

For the first 2 years after the death of a spouse, the widow or widower who has a dependent son or daughter will be entitled to the same income-splitting privilege as is accorded married couples.

A taxpayer can claim a $600 dependency deduction for a foster child or a child living in the taxpayer's household while awaiting adoption, or for a cousin who is cared for in an institution because of physical or mental disability, if he had previously been a member of the household.

—Sarah L. Doran

Birth Weight

The first national study of survival of the newborn in relation to weight at birth has recently been completed by the National Office of Vital Statistics, Public Health Service, Department of Health, Education, and Welfare.

The report is based on data for births in the first 3 months of 1950 and neonatal deaths among these children.

Statistics in the study indicate the magnitude of the immaturity problem in the United States and the level of mortality among both the immature and mature infants. Babies weighing 2,500 grams (5 pounds 8 ounces) or less at birth represented only 7.4 percent of all births in the study but accounted for two-thirds of the neonatal deaths. The neonatal mortality rate among these infants was 173.7 per 1,000 as compared with 7.8 among all other children. The lowest mortality (5.6) was experienced by children 3,501–4,000 grams (7 pounds 12 ounces–8 pounds 13 ounces). Detailed data by race, sex, plurality, attendant at birth, and period of gestation also appear in the report. Copies are available from the National Office of Vital Statistics.

Mentally Retarded

A number of recommendations to improve the lot of New Jersey's mentally retarded have been recently made in the final report of a 3-year-old gubernatorially appointed State commission on the problem. These include: immediate establishment of at least two more institutions to relieve the serious overcrowding in the State's four public training schools for the mentally deficient; better salaries and living conditions for institutional employees; establishment of courses for professional workers in this field, as well as scholarships, fellowships, and inservice training programs.

The commission has also urged the expansion of two State programs for the mentally retarded: the "home training service," a program which now employs three teachers to work with retarded children and their parents in their own homes; and the "service center plan," which in a center away from the institution helps institutionally trained girls prepare for free life in the community through a "vacation" or a trial period of employment.

The commission has also recommended that the Department of Education take more responsibility for the education and training of mentally deficient school-age children; that the new Bureau of Research in the Department of Institutions and Agencies employ qualified personnel for research in prevention and control of mental deficiency; that a coordinated list of mentally deficient persons be maintained.

The report notes that a number of steps have already been taken in line with the commission's recommendations, among them the earmarking of $10,000 by the Department of Education for a statewide census of all handicapped children.

Adoption

First steps in New York State's announced intention to bring about improved adoption services were taken recently by the State Department of Social Welfare when it appointed an adoption consultant to each of its five area offices. Their job, according to an announcement from the department, is to carry on a "continuing analysis of adoption possibilities; extensive training in adoption services; pooling of homes, children, and resources; and improvement in the staffing and organization of public adoption facilities."

The plan looks to the development of joint adoption services by counties in an effort to offer opportunities for adoption to children now in foster care. The State Department of Social Welfare has announced its intention to share with local welfare departments the costs of necessary additional staff for tasks essential to adoptions.

Staff Selection

In response to a long-time need expressed by State public welfare agencies for help in improving their methods of selecting social workers, the Children's Bureau and the Bureau of Public Assistance recently held a 2-week workshop for State staff responsible for interviewing candidates for social-work jobs. The workshop, which was financed in part by the Field Foundation, was held at the New York School of Social Work, August 23 to September 3, under the leadership of Sidney Berengarten and Irene Kerrigan of the school's staff. Sixteen State public welfare departments were represented.

The purpose of the workshop was to train selected State representatives in interviewing applicants and in assessing their personal suitability for social work. As a part of the workshop process the participants interviewed a number of applicants who had volunteered to take part in this procedure.

In evaluating the applicants' suitability for social work the interviewers used criteria that had been developed as the result of a 5-year research project sponsored by the New York School of Social Work. These criteria give special emphasis to such personal factors as emotional maturity, flexibility, and the ability to relate to a wide range of people. The criteria are being used by schools of social work in selecting candidates for admission, and are beginning to be used by State public welfare departments in selecting personnel for social-work positions.

Migrants

Last summer three Western States joined hands to provide continuity of health care to some thousands of children of migratory agricultural laborers. As part of a health program for all migrants at Fort Lupton, Colo., the children under 6 years old in the labor camp were given the first of a series of injections to immunize them against diphtheria, whooping cough, and tetanus. By the time the next injection was due, a month later, some of the families had moved into other parts of Colorado as well as into Wyoming and Montana; and the local health departments of those places, at the request of Colorado's Department of Public Health, completed the series.

Other phases of the Fort Lupton health project covered adults as well as children and included medical, X-ray, and laboratory examinations for communicable diseases; treatment of persons with venereal disease; and hospitalization of the tuberculous. The project was carried on by the Public Health Service, of the U. S. Department of Health, Education, and Welfare, in cooperation with Colorado's State Department of Public Health and the Weld County Health Department.

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The Colorado Department of Health has recently designed a program to provide services to families of migrants in counties throughout the State, with emphasis on maternal and child health. Planned to go into operation next summer in a number of counties the program will provide or arrange for immunization services, obstetric services and some other types of medical care through existing facilities or, where there are none, in newly developed facilities. Follow-up by arrangement with other States, as occurred in the Fort Lupton project, will be encouraged.

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During much of the past summer about 50 children of migratory agricultural laborers working in Potter County, Pa., were served by a day-care center established as a direct result of the Conference on East Coast Migrants held in Washington last spring.

Soon after the conference, the Governor's Interdepartmental Committee on Migrants, which represents Pennsylvania's health, education, welfare, labor, and other departments, met with the Pennsylvania Citizens Committee on Migrants and other voluntary agencies to plan followup action. The group decided to operate a day-care center, as a pilot project, in Potter County, where about 200 children of migrant families were due to arrive for an 8-week stay.

Officially sponsored by the Interdepartmental Committee, the center was supported financially by two departments—Welfare and Labor and Industry—and by the Pennsylvania Citizens Committee. Small fees were paid by parents.

Though only a small fraction of the children in the migrant group could be served at the day-care center, it proved so valuable that it won first place in a national competition for community projects as an outstanding example of joint planning between public and voluntary agencies. The Pennsylvania Citizens Committee on Migrants, for its efforts in promoting the center, was awarded $5,000 by a foundation.

Besides the Citizens Committee, other agencies that contributed to the success of the center included the Governor's Committee on Children and Youth, the American Friends Service Committee, the Pennsylvania Council of Churches, the Division of Home Missions of the National Council of Churches of Christ in the U. S. A., and the National Child Labor Committee.

Unmarried Mothers

As a step toward improving adoption practices, Los Angeles County's Committee on Unmarried Parents has recommended measures leading to a sound program to help unmarried mothers and their babies. The committee recommends: additional casework service for the estimated 1,000 unmarried mothers who each year give away babies without protective service; arrangements between social agencies so that no mother is denied service; financial help—emergency and long-term—for these mothers and their babies; community payment for medical care when other sources are lacking; foster-family homes for temporary shelter before and after the baby is born; central statistical reporting to determine the need for services; research into the underlying problems that lead to relinquishment of babies for adoption; and planned public information on the need for support of programs for unmarried mothers.

The committee is part of the Citizens Adoption Committee of Los Angeles County.

The cameraman shoots a juvenile-court scene for "HARD BROUGHT UP—a Child Welfare Story," a film produced for the Mississippi State Department of Public Welfare by Potomac Film Producers. This 40-minute black and white sound motion picture, reveals the whole spectrum of child-welfare services, focusing especially on a child-welfare worker's efforts to help unravel the personal and family problems of two delinquent boys. Interpreting child-welfare services to the layman, the film is also useful for staff training, orientation, and recruitment. Prints may be purchased from Filmbuilders, Ltd., 1536 Connecticut Avenue NW., Washington, D. C., or rented through film libraries.

Retrolental Fibroplasia

A 3-year study of the causes of retrolental fibroplasia is to be made by the National Society for the Prevention of Blindness, with the help of a $15,000 grant from the E. Matilda Ziegler Foundation for the Blind.

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Results of 6 months of study in 18 hospitals of the relation of oxygen to retrolental fibroplasia were reported at the annual meeting of the American Academy of Ophthalmology and Otolaryngology in September. In this period 72 percent of the 53 premature infants surviving 6 months after receiving routine oxygen treatment developed retrolental fibroplasia. Only 30 percent of the 245 surviving infants in a limited-oxygen group developed the disease. The two groups showed no difference in mortality.

The study, which is continuing, is being sponsored by the National Institute of Neurological Disease and Blindness, of the Public Health Service, Department of Health, Education, and Welfare; the National Society for the Prevention of Blindness; and the National Foundation for Eye Research.

Population

According to current estimates by the United States Bureau of the Census, the Nation's child population is growing bigger each day, with an average daily net gain of close to 4,700 in the number of children under 18 years of age.

Other Census Bureau estimates indicate that in 1954 the number of children under 18 years of age reached a new high of almost 54 million—an increase of more than 13 million, or 33 percent, since 1940. The most striking increases occurred among the children under 5 years of age (70 percent) and those 5 through 9 years (53 percent).

Between 1954 and 1965 the number of children under 18 is expected to rise by approximately 25 percent—to a total of almost 67 million. In this period the number of boys and girls 10 to 17 years old is expected to increase by about 50 percent, as the large number of children born in the late 1940's and early 1950's enters the age group 10–17 years.

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An estimated 38 million children and young people—23 percent of the total population of the United States—will be enrolled in schools and colleges during the school year 1954–55, according to S. M. Brownell, Commissioner of

Education, U. S. Department of Health, Education, and Welfare. Enrollment in elementary schools will be greater by 6 percent over last year; in high schools, 3 percent; in colleges, the number enrolled is expected to increase by less than 1 percent.

Nutrition

A 3-year study of food habits in New Mexico, carried out cooperatively by the State Agricultural Experiment Station and the Maternal and Child Health Division of the State Department of Health, has recently been completed. Undertaken with the purpose of helping nutritionists, home-demonstration agents, and health and welfare workers in their efforts to achieve better nutrition in their communities, it revealed an excessive use of sweets and insufficient use of protein and vitamin-C rich foods throughout most of the State. The information was gathered at well-child conferences; at maternity, orthopedic, school, and preschool clinics; and from written records kept by school children.

A report of the study has been issued as Bulletin 384 of the Agriculture Experiment Station, New Mexico College of Agriculture and Mechanic Arts.

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In 1953 the number of local health departments employing full-time nutritionists increased by 15 percent over the figure for 1952, according to information gathered by the Children's Bureau.

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For the first time a regional workshop has been held for professional nutrition workers in such varied fields as agricultural extension, education, industry, research, and public health. The 3-week workshop was held last summer at Virginia Polytechnic Institute. Alabama, Arkansas, Florida, Louisiana, Maryland, North Carolina, South Carolina, Tennessee, Vermont, and Virginia were represeuted.

Operating Costs

Recently released figures from a number of organizations show the effects of post-World War II inflation on the costs of providing services to children. Data collected by the American Hospital Association reveal that hospital expenses jumped 136 percent between 1945 and 1953. Salaries of medical personnel in State health departments rose 63 percent between 1947 and 1953, according to figures from the Public Health Service, Department of Health, Education, and Welfare. Statistics collected by the National League for Nursing show comparable rise—60 percent between 1945 and 1952—in salaries of public-health nurses in county health departments. Similarly, the statistical reports received by the Children's Bureau show a 57 percent increase between 1946 and 1953 in the salaries of child-welfare workers in public welfare departments.

Health Careers

With the financial support of the Equitable Life Assurance Society of the United States, the National Health Council recently launched a nationwide project known as Operation Health Career Horizons to interest young people in preparing for jobs in health services. The medical and health professions are also cooperating in the work.

Information on professional, technical, and supporting jobs in the health fields will soon be made available to young people and their families—high-school graduates, high-school students, and college students—as well as to vocational-guidance counselors, teachers, administrators in high schools, colleges, and universities, and to community leaders and the general public.

Heart Conference

About two-thirds of the 244 children who were improved by the Blalock-Taussig operation at Johns Hopkins Hospital for the "blue baby" congenital heart condition were maintaining their gains 5 to 8 years later. This was reported at the Second World Congress of Cardiology, which met at Washington September 12–18, along with the 27th scientific sessions of the American Heart Association.

Followup lasting from 3 months to 4 years was reported on 69 of 86 blue babies who underwent an alternative operation, devised by Sir Russell Brock of England. Virtually all of the 69 showed improvement.

New heart operations have made motherhod safe for many women iu whom serious heart disease would have ruled out the possibility of successful pregnancy a few years ago, Dr. Curtis L. Mendelson of New York stated. Most of the heart damage among young women of childbearing age is caused by rheumatic fever, said Dr. Mendelson, and this condition now lends itself to corrective surgery.

Reminding the group that blue babies are highly susceptible to tuberculosis, Dr. S. D. Doff, of Jacksonville, Fla., recommended that precautionary X-rays be taken of all persons who come into contact with them, whether in the home or the hospital.

Visiting Specialists

Thirty-seven specialists in maternal and child health or child welfare who have come to the United States under the auspices of the Foreign Operations Administration, the World Health Organization, or the United Nations, are currently studying or observing operations in this country under programs arranged through the Children's Bureau. Most of these specialists are from countries where work to improve health and welfare is just beginniug to take on national importance.

The largest number, 14, have come from the Middle East; 12 are from Latin America, 6 from Europe, 3 from the Philippines, and 1 from Japan. Twenty-three are concerned primarily with health, including 4 who are in medical social work; 14 are mainly interested in some aspect of social services for children or youth.

Twenty-four of the visitors are enrolled in educational institutions in various parts of the United States—11 in schools of public health, 11 in schools of social work, 1 in a postgraduate course in a school of medicine, and 1 in a school of dentistry. Three are on hospital staffs, as assistant resident physicians, interne, and externe. The remaining 10 are observing programs in various facilities throughout the country.

Home Safety

Georgia's State Health Department is carrying on a demonstration project in home-accident prevention with the help of a grant from the Kellogg Foundation. Staffed by a medical director, an engineer, a nurse, a public-relations officer, and a clerk, the project is using the regular channels of instruction in maternal and child health—well-child conferences, mothers' classes, midwives' classes, and home visits.

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Home safety for babies and preschool children is also being promoted in New

Jersey, where the State Congress of Parents and Teachers, the New Jersey Safety Council, and the State Health Department are cooperating in a joint program. First step in the program was a questionnaire distributed to 30,000 homes in an effort to learn about parents' attitudes and judgments in situations involving accident hazard. The findings are now being tabulated by the National Safety Council.

Institutions

Upon recommendations by the Child Welfare League of America, the Children's Village, Dobbs Ferry, N. Y., a voluntary residential treatment school for disturbed and delinquent boys, with a capacity of 300 children, has reorganized its program and administration. The institution has reduced the number of children accepted, scheduled the activities more flexibly in order to meet the boys' individual needs, and integrated the educational, child-guidance, and cottage-life programs in accordance with sound treatment principles.

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Completion of a new wing at the Astor Home at Rhinebeck, New York, will considerably enlarge the capacity of this residential treatment center for emotionally disturbed children, now accommodating 27 patients. Operated by the Catholic Charities of New York, the home is one of three pilot projects of this type sponsored by the New York State Mental Health Commission.

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Children's Services of Connecticut, a private child-caring agency, has reorganized its program to provide institutional services to emotionally disturbed children. The institution has four cottages with a capacity of 15 children each. Besides a full-time psychiatrist and a psychologist, the personnel includes a social worker for each cottage.

Crippled Children

Ninety-nine percent more children with congenital heart defects received physicians' services under State crippled children's programs in 1953 than in 1950, according to reports from State services for crippled children. Another large increase—77 percent—took place among children with eye conditions; and an increase of 69 percent among those with epilepsy. The group with orthopedic handicaps increased only 11 percent, but in both years this group made up more than half the children served.

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Michigan's Crippled Children's Commission is cooperating in the program of the U. S. Army Prosthetic Research Laboratory in developing prosthetic appliances for children with amputations. The State program is developing molds for the manufacture of smaller-size hands, to be made according to the specifications of the research group.

Here and There

Nearly half (48 percent) of the 3,187 counties in the United States had no full-time public child-welfare worker in 1953, according to reports from State welfare departments. Thirty-six percent had less than 1 such worker per 10,000 children under 21, and only 16 percent had 1 or more per 10,000.

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Japan's Children's Bureau, in the Ministry of Welfare, has published, in the Japanese language, the Digest of the Fact-Finding Report to the Mid-century White House Conference on Children and Youth.

SOME INTERNATIONAL PUBLICATIONS

STUDY ON ADOPTION OF CHILDREN; a study on the practice and procedures related to the adoption of children. United Nations, Department of Social Affairs. New York. 1953. 103 pp. For sale by International Documents Service, Columbia University, 2960 Broadway, New York 27, N. Y. 75 cents.

At the invitation of the United Nations, the International Union for Child Welfare, Geneva, collected the material for this study, which is based on answers to a questionnaire sent by the Union to its member agencies and other child-welfare agencies in a number of countries. Included in the report are information and conclusions brought out at a conference held in Geneva in 1952. It also contains some discussion of legislation on the basis of an analysis made by the United Nations, to be published separately.

An effort was made to cover countries with different legal systems and different social and cultural patterns. Eight European countries, three Canadian Provinces, three States in the United States, and five Latin-American countries are represented.

This study is one aspect of a larger United Nations study of children deprived of normal home life.

MENTAL HYGIENE IN THE NURSERY SCHOOL; report of a joint WHO-UNESCO Expert Meeting held in Paris, 17–22 September 1951. United Nations Educational, Scientific, and Cultural Organization, 19 Avenue Kléber, Paris 16, France. 1953. 36 pp. 20 cents.

Ninth in a series on Problems in Education, this report discusses such subjects as the child's needs and the role of the mother in the early stages, the role of the nursery-school teacher, recruitment, selection, and training of nursery-school teachers. In a final paragraph on public opinion the report says that "the nursery school itself, by doing its work properly, can probably make a more far-reaching impression upon public opinion than can any mass public-information campaign."

EXPERT COMMITTEE ON POLIOMYELITIS; first report. Technical Report Series No. 81. World Health Organization, Palais des Nations, Geneva, Switzerland. April 1954. 69 pp. For sale by International Documents Service, Columbia University Press, 2960 Broadway, New York 27, N. Y. 50 cents.

"It is not surprising," says the Expert Committee on Poliomyelitis, in this report, "that news of fresh discoveries in laboratory methods and in the epidemiology and control of poliomyelitis should arouse widespread interest. It was primarily to consider the place of these discoveries in future efforts to control the disease that the committee was convened."

As a necessary step in this direction, the committee in its first report reviews current knowledge and opinion on various aspects of poliomyelitis, "so that theories which can no longer be considered valid could be discarded and replaced by interpretations in keeping with the observed facts."

READERS' EXCHANGE

JUVENILE COURTS: Bad illustration

I would like to call your attention to the picture of a Juvenile Court hearing on page 133 of the July–August issue of CHILDREN. ("Parents and Delinquency," vol. I, no. 4.)

This would seem to picture a hearing as it should *not* be rather than an ideal type of juvenile court hearing. The better type of juvenile courts today all conduct their hearings in a roundtable fashion with the judge and 11 parties participating seated on the same floor level. Nothing so brands a juvenile court as out of date and old-fashioned as to have the child with a uniformed officer, together with the parents, stand before the judge as in an ordinary police-court hearing. We believe an organization such as the Children's Bureau should *set* standards rather than picture improper standards.

It is rather a hobby of the writer to try to modernize juvenile-court procedures and get away from old police-court type of hearings, which are now entirely passé in the better-type courts. With the judge and all participants seated on floor level and in a roundtable type of hearing, parents and children are placed at ease, the truth is more easily procured, and the welfare character of the court is emphasized.

I have described this in more detail in an article, "Helpful Practices in Juvenile Court Hearings," in the June 1949 issue of *Federal Probation*, published by the United States Department of Justice.

Walter H. Beckham, Judge, Juvenile and Domestic Relations Court, Miami, Fla.

YUM: What about results?

In her article on the Michael Reese Nursery Louise Yum gives us a picture of an excellent therapeutic nursery school for cerebral-palsied children. ("A Nursery School for Cerebral-Palsied Children," CHILDREN, Vol. 1, No. 4.)

As Mrs. Yum makes clear, the school's objective is for each child to develop on a par with his own possibilities into a healthy and whole personality. However, she omits two subjects of concern to anyone planning a therapeutic nursery school or already operating one. The Michael Reese nursery school, with its capacity of 14 and its large staff of specialists is clearly an expensive operation, offering optimum service. It would be useful to know just what results have been achieved. Some quantitative as well as qualitative information on results would help persons attempting to establish nursery-school programs of maximum effectiveness on limited budgets.

Secondly, Mrs. Yum notes that the school was originally established as a demonstration and experimental center. It would also be of service to many readers to know what information is available on results in these two areas of the school's program and where the information can be found.

Lawrence J. Linck
Executive Director, National Society for Crippled Children and Adults, Inc.

CAPLAN: A simple principle

The prenatal clinic described by Gerald Caplan ("Preparation for Parenthood," CHILDREN, vol. 1, no. 5) is guided by a simple universal principle—that every experience in life makes a psychological impact. This impact may be for better or for worse. In the past for the most part the psychological impact of the prenatal clinic has been unplanned and its effects have been left pretty much to chance. Depending largely upon the intuitive capacity of a staff, it might turn out to be good or bad. The work has been routinized and so has not varied with the needs of the case. Nor was this impact considered to be a part of the scientific armamentarium of the clinic harmonized with the needs of the child or his parents.

In this Harvard program the psychological aspects of the clinic are controlled just as the diet would be. Furthermore, the examination of the patient is designed to reveal his psychological needs. In order to accomplish the desired result it is, of conrse, essential that the members of the clinic team function as a unit, all pulling in the same direction. In this clinic the team effort is facilitated by the avoidance of overspecialization. Each member of the team is supposed to know enough about the fields of the other members of the team so that he can incorporate in his work the simpler functions of the others that are common to the group.

The clinic is impressed with the unfortnnate impact of some current aspects of parent education. It seems that the stress on the importance of parental affection for the child is stirring up undne emotions of guilt and anxiety among parents. It is good to know that our communications are reaching parents. The next step is to make our communications as constructive as possible.

George S. Stevenson, M. D., National and International Consultant, The National Association for Mental Health, New York, N. Y.

BECK: Service and sacrifice needed

I have just read the report in CHILDREN on the recent Washington Conference on Juvenile Delinquency ("Steps to Combat Delinquency," by Bertram M. Beck, CHILDREN, vol. 1, no. 5).

We study and talk about and legislate about juvenile delinquency as though it was some specific situation which could be remedied by the application of a formula or prescription when, as a matter of fact, juvenile delinquency is a symptom and we will reduce juvenile delinquency only as we improve the heritage and environment in which our children are born and raised.

The attack on juvenile delinquency is an attack on all deleterious influences, but more than all that, it must be an attempt to revive and maintain the spirit of service and sacrifice among our American people. A democratic civilization cannot survive on the theory that the Government will provide for everyone. The Government is made up of all of us and only as we contribute to and work for a democracy can we expect to receive its benefits.

Sanford Bates, Consultant on Public Administration, Trenton, New Jersey.

Photo Credits

Pages 213 to 215, National Foundation for Infantile Paralysis.

Pages 223 and 225, Singer for the Department of Health, Education, and Welfare.

SOME U. S. GOVERNMENT PUBLICATIONS FOR PROFESSIONAL WORKERS

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CHILDREN'S BUREAU STATISTICAL SERIES. Single copies available from the Bureau without charge.

Juvenile Court Statistics, 1950–52. No. 18. 1954. 20 pp. This issue shows graphically and in tabular form how the volume of juvenile-court cases of delinquency increased in 1952 for the fourth consecutive year. From 1951 to 1952 the rise was 10 percent; for the period 1948–52 it was 28 percent. Juvenile-court cases of dependency and neglect increased 4 percent over the figure for 1951, continuing a rise which began in 1950.

Selected Child Welfare Expenditures by State and Local Public Welfare Agencies, 1952. No. 19. 1954. 17 pp. The data indicate that nearly three-quarters of the money spent by State and local public-welfare agencies went for payments for the support and care of children in foster care, the rest for professional services and for administration.

Diagnoses of Children Served in the Crippled Children's Program, 1950. No. 21. 1954. 26 pp. Among 214,000 children served in 1950 by State crippled children's programs aided by Federal funds diagnoses were established in 93 percent, this report shows. Four major diagnostic groups accounted for two-thirds of the impairments: congenital malformations; diseases of the bones and organs of movement; poliomyelitis; and cerebral palsy.

Personnel in Public Child Welfare Programs, 1953. No. 20. 1954. 14 pp. Three percent more full-time professional workers were employed in public child-welfare programs in 1953 than in 1952, but at the end of 1953 vacancies were still numerous, according to this report.

Educational Leave in the Public Child Welfare Program, 1952. No. 22. 1954. 22 pp. The study reported was conducted jointly by the Children's Bureau and the Bureau of Public Assistance of the Department of Health, Education, and Welfare. It shows that in 47 States 500 persons employed by State and local public child-welfare agencies concluded educational leave in a year ending August 31, 1952. They represented 10 percent of all the persons in the agencies employed full-time in social-work positions.

JOB GUIDE FOR YOUNG WORKERS. U. S. Department of Labor, Bureau of Employment Security. 1954. 46 pp. 30 cents.

Addressed to young people, this bulletin contains information on beginning jobs in fields of work where thousands of opportunities occur each year for boys and girls—jobs that require not more than a high-school education.

YOUR CHILDREN'S FEET AND FOOTWEAR. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. CB Folder 41. 1954. 13 pp. 10 cents.

This illustrated folder offers help to parents in caring for their children's feet. It includes an 11-point guide to use when buying shoes for a child.

MOTION PICTURES ON CHILD LIFE: supplement No. 1. Compiled by Inez D. Lohr. U. S. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. 1954. 16 pp. 15 cents.

This supplement includes annotations to 38 films that have become available since the original bulletin came out, in 1952.

MEDICAL SOCIAL SERVICES FOR HOSPITALIZED CHILDREN. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. 1954. 28 pp. Processed. Single copies available from the Children's Bureau.

This pamphlet presents principles and agreements growing out of a discussion among medical social workers in State maternal and child health and crippled children's programs and in hospitals.

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